Fifth Edition

Edited by

H. Thompson Prout & Alicia L. Fedewa

Counseling and Psychotherapy with Children and Adolescents

Theory and Practice for School and Clinical Settings

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WILEY

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Contents

Preface *vii*

About the Editors *ix*

Contributors *xi*

1 Counseling and Psychotherapy with Children and Adolescents: Historical, Developmental, Integrative, and Effectiveness Perspectives 1
H. Thompson Prout and Alicia L. Fedewa

2 Ethical and Legal Issues in Psychological Interventions with Children and Adolescents 25
Alicia L. Fedewa, Susan M. Prout, and H. Thompson Prout

3 Culturally Responsive Interpersonal Psychotherapy with Children and Adolescents 61
Janine Jones

4 Play Therapy: A Child-Centered Approach 91
Sue Bratton, Katherine Purswell, and Kimberly Jayne

5 Cognitive-Behavioral and Behavioral Approaches 115
Rich Gilman and Kathleen Chard

6 Rational Emotive Behavior Therapy 155
Raymond DiGiuseppe and Oana Alexandra David

7 Reality Therapy Approaches 217
Gerald B. Fuller

8 Solution-Focused Approaches 279
John J. Murphy

9 Systemic Approaches: Family Therapy 317
William B. Gunn Jr., Joni Haley, Anne M. Prouty, and Janet Robertson

10 Children and Adolescents with Disabilities: Implications for Interventions 357
Jonathan M. Campbell, Lisa A. Ruble, and Rachel K. Hammond

Author Index 399
Subject Index 407

Preface

This is now the fifth edition of this volume. As noted in the Preface of the fourth edition, the impetus of the first edition was really based on a lack of books and resources on child/adolescent counseling and psychotherapy. My—how things have changed! In our preparation for this volume, we did a number of things. First, we reviewed the four earlier volumes and looked at the "trajectory" of how the field has grown and expanded. This was an interesting examination—the area now has multiple intervention and treatment options and a much stronger empirical base. Second, we looked at trends in the field—where children and adolescents were being treated, what are the issues and problems facing today's youth, and what are the range of treatment options. Importantly, what are the most contemporary approaches?

Our goal for this volume remains much the same as the first volume—to provide a comprehensive overview of major approaches for helping children and youth experiencing social-emotional difficulties. We also feel it is important to understand the context of child/adolescent treatment. Ethical and legal concerns, diversity issues, and issues relating to disabilities potentially all have impact regardless of theoretical approach. In the first volume, we used the term *intelligent eclecticism*. We obviously believe in the importance of theory as being the base of our interventions but we also encourage professionals not be bound to a single theory. Our belief is that professionals can utilize a range of perspectives and blend approaches depending on the circumstances, and thoughtfully (i.e., intelligent eclecticism) develop comprehensive approaches to working with children and youth. It is also clear that counseling and therapy with youth does not occur in a vacuum—comprehensive interventions that include counseling and therapy also should consider the various systems that impact children. In addition to direct work with a child, successful interventions often include teachers, parents, other family members, and community social supports.

We made a number of changes in this volume. We added chapters on solution-focused approaches and a chapter on play therapy. We also eliminated some chapters in order to be able to present what we judged as the most contemporary perspectives. This volume also includes several new chapter authors who are leaders in their respective fields.

All chapters are thoroughly updated to reflect the most current literature and evidence-based therapy in child psychotherapy.

In a volume of this nature, we offer sincere thanks to our chapter authors. We thank these colleagues who reviewed the book and provided valuable feedback: Callen Fishman, PsyD, assistant professor, Division of Counseling and School Psychology, Alfred University; Cindy Plotts, PhD, professor, School Psychology Program, Texas State University at San Marcos; Mendy Mays, EdD, assistant professor, Department of School of Professional Counseling, Lindsey Wilson College; Maxine L. Rawlins, PhD, professor, Department of Counselor Education, Bridgewater State University; Melissa Laracuenta, PsyD, clinical associate professor, Fordham University. We also thank Wiley for its support and encouragement on this project. Rachel Livsey and Melinda Noack have been extremely helpful as the project has progressed.

Instructor's supplements are available at www.wiley.com/go/prout. The supplements include instructor's manuals, test banks, and PowerPoint slides.

H. Thompson Prout
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About the Editors

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CHAPTER

1

Counseling and Psychotherapy with Children and Adolescents

Historical, Developmental, Integrative, and Effectiveness Perspectives

H. THOMPSON PROUT AND ALICIA L. FEDEWA

The psychological treatment of children's problems is the focus of several professions and is carried out in many settings and situations. Although theoretical viewpoints are wide-ranging and essentially rooted in adult-based theories, the child or adolescent presents a unique challenge to the child mental health worker. Children are not simply little adults. Their treatment cannot be viewed as scaled-down adult therapy; their developmental stages, environments, reasons for entering therapy, and other relevant factors necessitate a different, if not creative, approach to therapy. The child/adolescent therapist must have an expanded knowledge base of the human condition and a different perspective of what constitutes therapy or counseling.

This book is about psychotherapy and mental health counseling with children and adolescents. It brings together in a comparative format the major theoretical views of psychological treatment of children and highlights major issues in the area. A number of concerns, however, cut across the theories and are relevant to any provision of mental health services to children. This introductory chapter describes some of these issues: Historical perspectives, the mental health needs of children and adolescents and the need for services, developmental issues, the unique aspects of child and adolescent therapy, a multimodal research/efficacy issues and evidence-based approaches. Throughout this chapter, the terms *counseling* and *psychotherapy* are used interchangeably.

HISTORICAL PERSPECTIVES ON THE MENTAL HEALTH NEEDS OF CHILDREN AND ADOLESCENTS

Many major advances in clinical mental health work can, in some way, be traced to Freud. Mental health work with children is no exception. Freud's classic case study of "Little Hans" in 1909 is generally viewed as the first reported attempt to psychologically explain and treat a childhood disorder (S. Freud, 1955). Although Freud did not directly treat Little Hans's phobia, he offered a psychoanalytic explanation of the problems and guided the father in the treatment of Hans. This case study is recognized as providing the base for Freud's theories on the stages of psychosexual development. Freud's interest in childhood disorders apparently waned at this point, and it was not until 1926 that his daughter, Anna, presented a series of lectures entitled "Introduction to the Technique of Psycho-analysis of Children" to the Vienna Institute of Psychoanalysis. These lectures generated considerable interest and established Anna Freud as a pioneer in child psychotherapy. Shortly thereafter, Melanie Klein (1932), emphasizing the symbolic importance of children's play, introduced free play with children as a substitute for the free association technique used with adults, thus inventing play therapy. Although these two camps disagreed on many issues, they have remained the dominant voices in the child psychoanalytic field, with most analytic work being a spin-off of either A. Freud or Klein.

At approximately the same time (the early 20th century), other forces were beginning to put more emphasis on work with children. In France in 1905, Alfred Binet completed initial work on his intelligence test, which was used for making educational placement decisions in the Paris schools. This work provided the base for the psychometric study of individuals and had great impact on child study and applied psychology. At the University of Pennsylvania in the United States, Witmer had established a clinic for children in 1896 that focused on school adjustment and in 1909 Healy founded what is now the Institute for Juvenile Research in Chicago. These events provided the base for the child guidance movement, emphasizing a multidisciplinary team approach to the diagnosis and treatment of children's adjustment and psychological difficulties. The child guidance model involved treating both the children and their parents. The increased interest in clinical and research work on children's problems led to the founding of the American Orthopsychiatric Association in 1924, an organization of psychologists, social workers, and psychiatrists concerned with the mental health problems of children.

Through the 1940s and into the 1950s, psychoanalytic psychotherapies were used almost exclusively in the treatment of children. In 1947, Virginia Axline published *Play Therapy,* describing a nondirective mode of treatment utilizing play. Nondirective play therapy was, in effect, a child version of Carl Rogers's adult-oriented client-centered therapy. Both nondirective play therapy and client-centered therapy represented the first major departures from psychoanalytic thought, differing in conceptualization of the

therapeutic process and content in the role of the therapist. Rogers's impact on adult psychotherapy was paralleled and followed by Axline's impact on child therapy. The next major movement in psychotherapy was the rise of the behaviorally based approaches to treatment. Although the principles and potential applications of behavioral psychology were long known, it was not until the 1960s that behavior modification and therapy began to be used frequently in clinical work with children. In recent years, cognitive-behavioral approaches have become prominent as a treatment modality.

The mental health treatment of children and adolescents has also been affected by two policy and legislative mandates. First, the community mental health movement was strongly influenced by the passage in 1963 of the federal program to construct mental health centers in local communities and begin a move away from large institutional treatment. This movement grew not only because it was mandated by a federal program but because it represented a philosophy that mental health interventions are more likely to be successful when carried out in the community where the maladjustment is occurring. The new programs emphasized early intervention and prevention of mental disorders. The second mandate, with a similar philosophical base, involved the provision of special education services to all handicapped children, including emotionally disturbed and behavior-disordered children and adolescents. Exemplified initially by Public Law 94–142 (now the Individuals with Disabilities Education Improvement Act [IDEA]), this movement has not only expanded the role of public education in provision of services to these children but also allowed more children to remain in their home communities. Psychotherapy and mental health treatment, if deemed a part of the total educational program of a child, has become by law and policy an educational service.

In the past 10 to 15 years, child and adolescent treatment has been in the identification of treatments that are evidence based (e.g., Kazdin, 2003; Weisz & Kazdin, 2010). Various terms have been used to describe these treatments including *empirically validated* or *supported treatments*, *evidence-based practice*, or simply *treatments that work*. Efforts have also been made to quantify the degree and strength of support for the treatments, for example, the number of studies showing evidence of effectiveness. Studies are examined with the specification of treatment (i.e., age, setting, presenting problem), use of treatment manuals or clearly specified intervention procedures, and evaluation of outcome with multiple measures. Procedures must be replicable and independent replication studies are often included in criteria for a treatment to be labeled as evidence based.

CHILD AND ADOLESCENT MENTAL HEALTH NEEDS: A CHRONIC PROBLEM

There are well-documented estimates of large and perhaps increasing numbers of children who are experiencing significant mental health problems. These needs have been apparent for some time. Studies in the 1960s and 1970s clearly showed the pervasiveness

of problems at that time. In a study of children in public school, Bower (1969) estimated that at least three students in a typical classroom (i.e., 10% of school-age children and adolescents) suffered from moderate to severe mental health problems; many of these children were disturbed enough to warrant special educational services for the emotionally handicapped. In 1968, Nuffield, citing an estimate of 2.5 to 4.5 million children under the age of 14 in need of psychiatric treatment, found indices of only 300,000 receiving treatment services. This figure represented services to roughly 10% of those in need. Berlin estimated in 1975 that each year there would be 6 million school-age children with emotional problems serious enough to indicate the need for professional intervention. Cowen (1973) noted a smaller group (1.5 million) in need of immediate help but estimated that fewer than 30% of these children were receiving this help.

There has been little change in the reduction of problems. Kazdin and Johnson (1994) noted that incidence studies show between 17% and 22% of youth under the age of 18 have some type of emotional, behavioral, or developmental problem. This represented between 11 and 14 million of the 64 million youth in the United States with significant impairment. They noted that many of those with disorders are not referred for treatment and are not the focus of treatment in the schools. Kazdin and Johnson (1994) also noted that there are high and increasing rates of at-risk behaviors, including antisocial and delinquent behaviors, and substance abuse. Doll (1996), in a synthesis of epidemiology studies, notes a similar rate of 18% to 22% with diagnosable disorders, translating this to the analogy of a school of 1,000 students with 180 to 220 students in the school having a disorder in the clinical ranges. Doll sees the need for broad-based policies at all levels (i.e., school, district, governmental) to address these significant needs. Regardless of the estimate of incidence, it is clear that many children and adolescents with problems are not identified by educational, mental health, and social service institutions as having emotional difficulties and thus are not referred for or provided treatment services.

Reviews (Huang et al., 2005; Tolan & Dodge, 2005) have noted this continued problem despite many government panels formed to address the problem. It is estimated that 1 in 5 children have a diagnosable disorder, with 1 in 10 having a disorder that substantially impacts functioning at home, at school, or in the community. Further, there continues to be limited or difficult access to appropriate mental health services, both for families with financial resources and those with more limited means.

Children and adolescents remain critically underserved populations, despite ample recognition of the problem based on nearly 40 years of research documenting needs. The mental health needs of children present an enormous service delivery shortfall; and with funding problems continuing in the human services, the gap between need and available services is likely to continue. Preventive services may be a cost- and resource-efficient mode for dealing with part of this problem, but the provision of quality counseling and psychotherapeutic services will be a crucial component in the total mental health

system. Tolan and Dodge (2005) call for a fundamental policy shift to development of a comprehensive mental health care system for children that includes treatment, support, and prevention.

Huang et al. (2005) have described a "vision for children's mental health" that would address the complex needs of children and adolescents, including:

- Development of comprehensive home- and community-based services and supports.
- Development of family support and partnerships.
- Development of culturally competent care and reducing disparities in access to care.
- Individualization of care.
- Implementation of evidence-based practice.
- Service coordination and designation responsibility.
- Prevention activities for at-risk groups with earlier identification and intervention, including programs for early childhood.
- Expansion of mental health services in the schools.
- The components of this vision are clearly consistent with the theme of this book.

The Centers for Disease Control (2013) released an updated survey of the status of children's mental health. Among the highlights of this report include the increasing rate for internalizing disorders (e.g., depression, anxiety), behavioral disturbance (ADHD, conduct), and autism spectrum disorders. The report noted that up to 1 in 5 children in the United States may experience a mental health disorder in any given year. Adolescent issues included substance use/abuse disorders and suicide. Labeling children's mental health as an important public health issue, the report called for increased understanding of the mental health needs of children, research on risk factors and prevention, and continued research on effectiveness of treatment and prevention efforts. Sadly, this report seems to echo studies from many years ago and points to even more needs in the child/adolescent population.

DEVELOPMENTAL ISSUES

The child/adolescent mental health professional must be familiar with human development for a number of reasons. With the exception of severe psychopathology or extreme behaviors, much of what is presented as problematic in children may simply be normal developmental deviation. What is considered pathological behavior in adults may not be abnormal in children or adolescents. Knowledge of development and the normal behavioral ranges at different ages is crucial to discriminating between truly deviant

behavior and minor developmental crises. Development in children and adolescents may follow sequences with expected orders for the appearance of certain behaviors and characteristics yet still tend to be highly variable. Children's personalities are quite unstable when compared with expectations of stability in adults. Related to this instability is the evidence that indicates normal development is often marked by a number of behavior problems. The child/adolescent therapist must be able to sort out these "normal" problems from those that may represent more serious disorders.

Awareness of development will also aid the therapist in clinical decision making at various points in the treatment process. Appropriate goal setting is important to any therapeutic venture. It provides a direction for our work, allows us to monitor progress, and tells us when we are done. The child/adolescent therapist sets these goals in a developmental framework and does not expect an average 8-year-old to acquire, in the course of therapy, the problem-solving cognitive abilities or the moral judgment of a 10-year-old. To set goals above developmental expectations is almost ensuring that the intervention will fail. This knowledge of development also allows the therapist to choose appropriate content and to decide what level of therapeutic interaction is best suited for the child. Within these developmental age expectations, the therapist must also be sensitive to developmental delays in children. Delays, particularly in cognition and language, dictate goal setting, yet they must be distinguished from behavioral or emotional disorders. These delays may also be major contributing factors in the development of disorders. On the other end of the spectrum, we need to be cautious not to set limited goals for developmentally advanced children. Although we are not advocating psychological assessment as a prerequisite for treatment, in most cases, the child/adolescent therapist will need to assess developmental levels of their clients early in the intervention.

An understanding of child and adolescent development appears critical for effective therapeutic interventions. The first involves an understanding of the developmental stage theorists, with the works of Freud, Piaget, Kohlberg, and Erikson being the most notable. It is beyond the scope of this book to detail this large knowledge and research base on human development, but comprehensive human development text should be on the shelf of every therapist.

As an example, we have personally found that Piaget's theory of cognitive development provides an excellent base assessing intellectual development and planning interventions accordingly. Piaget suggested that maturation, physical experience, social interaction, and equilibration (the internal self-regulating system) all combine to influence cognitive development. At different periods, the type of information that can be processed and the cognitive operations that can be performed vary. Cognitive development is a coherent and fixed sequence with certain cognitive abilities expected at certain ages (e.g., see Wadsworth, 2003). Piaget allows us to select developmentally appropriate modes of interacting with the child and to set appropriate goals for cognitive change.

For example, children in the concrete operations stage solve problems involving real or observable objects or events. They have difficulty with problems that are hypothetical and entirely verbal, making verbally oriented or more abstract counseling interventions inappropriate at this developmental stage, while children in formal operations can engage in broader and more abstract and generalizable problem solving.

Probably no single developmental period provides more confusion and consternation for parents, teachers, and clinicians than adolescence. It is characterized more by a developmental phase than by a set, sequenced series of stages. Mercurial behaviors, many of them disturbing, seem to "possess" the adolescent.

Both Steinberg and Morris (2001) and Smetana, Campione-Barr, and Metzger (2006) view adolescence in context beyond the typical developmental theories with an emphasis on interpersonal and societal contexts. Issues of parent-adolescent relationships, broader family relationship (e.g., siblings, extended family), peers, romantic relationships, and connection with community and school all impact the individual adolescent. Dolgin (2010) notes that today's adolescent is dealing with a wide range of issues. Social media and cell phones have become prominent as well as diversity issues. Adolescence is marked by biological and cognitive changes and a range of identity issues—education, sexual identity, educational aspirations, ethnic identity, and gender issues. Dolgin (2010) also notes that there really is no typical family constellation that is common to adolescents. The adolescent is faced with many developmental issues and now with a different set of cognitive skills to process and analyze these changes. The lability often seen in adolescents is likely the norm.

The child/adolescent therapist will find much in theory and research in child and adolescent development that pertains to psychological interventions with these groups. It is difficult to imagine developing and carrying out treatment plans without a firm grounding in these areas. Developmental theory and broader contextual perspectives provide us with a framework to systematically, if not scientifically, work with children and adolescents and more objectively gauge our therapeutic progress with them.

UNIQUE ASPECTS OF PSYCHOTHERAPY WITH CHILDREN AND ADOLESCENTS

In addition to the developmental issues previously discussed, a number of other issues related to the child's development and situation have an impact on the psychotherapeutic relationship. These factors relate to the direct work with the child or adolescent and stem from some of the differences between child/adolescent psychotherapy and adult psychotherapy.

Children and adolescents bring a different motivation for treatment into the counseling situation. Whereas the adult is usually aware that a personal problem exists, the

child may not agree or recognize that there are problems or concerns. Although others may encourage adults to seek professional help, in most cases they will decide whether to enter treatment. The child is unlikely to voluntarily initiate entering into therapy. This decision is usually made by an adult in the child's environment, with some varying degree of acceptance/compliance/resistance from the child. The involuntary nature of the child/adolescent client in many cases may yield little or no motivation on the part of the client to engage in a relationship with the therapist or not even an admission that any change is necessary. Thus, the first step in many interventions may be simply to establish some type of relationship with the child and to come to some agreement that change is necessary. Without developing some motivation in the client to at least examine the current situation, even if done nonjudgmentally, it will be difficult to make significant progress.

An aspect related to motivation is the child/adolescent's lack of understanding of both the therapeutic process and the treatment objectives. The adult is likely to recognize the need to "get something out of therapy" and to have certain expectations of what is supposed to happen in the counseling situation. The adult usually will be able to verbalize some expectations and goals and to engage in some role-appropriate "client behaviors," (e.g., talking, reflecting, responding to questions). Children may have no clear view of what the therapy situation presents. This blurred view may range from having total misinformation to seeing the therapist as an agent of their parents, the school, the courts, or some other individual or institution that forced the initiation of treatment. The therapist may initially have to simply educate the child about therapy, explaining what it is and what it is not. Children may bring in distorted or stereotyped ("Oh, so you're the shrink. Where's your couch?") perceptions of therapists. This author is reminded of one extremely anxious 12-year-old boy who failed to respond to the usual reassuring techniques in an initial therapy session. After some gentle probing, it was learned that the young man had watched one too many late-night horror movies in which the fiendish doctor had done bizarre things to his subjects. Somehow the boy had associated coming to the mental health clinic with the scenes in movies where the hero gets wired to a machine and is never the same again. When I (H.T. Prout) reassured him that the use of electrodes was not part of my approach and that we were simply going to talk about problems he was having at home and school, he visibly relaxed and began to volunteer all sorts of information.

Even as therapy progresses, it is necessary to monitor these perceptions. The child who views the therapist as the person he plays games with once a week is unlikely to focus on the tasks necessary to facilitate change. Similarly, there may be little agreement as to what changes are needed and what mutually acceptable treatment objectives are to be established. The therapist is likely to be faced with the predicament of reconciling, on the one hand, the goals of those who initiated treatment (e.g., parents,

teachers) and, on the other hand, the child or adolescent client's own view of what is needed. A parent-referred adolescent who has been arrested three times for shoplifting may verbalize a goal of having his parents "get off my case." Although this position may be a factor in the acting out, it is not likely to produce an appropriate therapy objective, given the referral problem. Thus, the therapist must negotiate with the client appropriate goals, objectives, and topics or content for the counseling. These goals may not necessarily be in total agreement with the aims of the referral source or the therapist, but they will provide a starting point. Objectives can always be renegotiated as the relationship develops. Further, the therapist needs to demonstrate to the child or adolescent client that the client will get something out of counseling. Initially, this demonstration may take a form as simple as providing an interesting format. This accomplishment can lead to the establishment of a more congruent set of objectives.

Another major difference between child and adult therapy is the child's more limited verbal and linguistic development, which is also related to the limitations in cognitive development. Children may be unable to think in more abstract terms and may have even more difficulty verbally describing and discussing their thoughts and emotions. This limited verbal ability is one of the main reasons play has been used as a medium of therapy. Play and other nonverbal techniques allow expression without creating anxiety or frustration for the child because of an inability to find the correct verbal description. Further, the child may not have the receptive vocabulary to fully understand what is being asked in the interview situation. This author once observed a psychiatric interview of a 7-year-old girl in which the resident asked the child if she ever had any hallucinations. The little girl, obviously not knowing what was meant by the word "hallucination," happily responded, "Oh, yes, all the time," whereupon the resident made note of this finding and continued the interview along other lines. Therapy must be geared at the appropriate developmental level for both the child's expressive and receptive language capabilities. While not de-emphasizing the worth of "talk therapy," alternative modes of expression should be investigated for use in conjunction with verbal interactions. The therapist may also find it useful to teach the child labels and verbal mediators for emotional experiences. This course of action can involve using the traditionally accepted labels for feelings or using the child's own terminology. An 8-year-old girl once accurately described several symptoms consistent with "feeling depressed." The girl, however, felt more comfortable generally describing the state as one of "yuckiness."

Children also differ from adults in terms of their dependence on environmental forces and changes. Children are reactors to changes in their living situations rather than initiators of change. They have relatively little power to take action to eliminate or prevent environmental causes of stress. They react to parental divorces, family moves, and school and peer pressures. The child's disturbance may actually be a relatively normal reaction to upheaval or stress in the environment. Yet, children cannot divorce their parents,

change schools, or move at will. Because the child is dependent on the environment, it is more important for those in the environment to be involved in treatment. Where the adult is more likely to seek treatment independently, the child is less likely to be treated in isolation. Even if children make significant progress in individual therapy, they still do not have the options available to adults in dealing with the environment. In some cases, therapy may even proceed on the notion of helping the child cope with a stressful situation, rather than assuming that change will be forthcoming in the environment. For example, an 11-year-old can exert little impact on the drinking and resulting behavior of an alcoholic parent yet may be assisted in finding ways to deal with the problem that make the stress more manageable.

Another factor that contributes to the difference between child therapy and adult therapy is that the child's personality is less likely to be set than the adult's. The child, whose defenses are not as well established, is more pliable and amenable to therapeutic influence once the relationship and cooperation are established. The personality is still developing and changing rapidly, yielding a greater potential for change. But at the same time, this situation presents a somewhat more labile client and can result in inconsistent responses in therapy session. The child has a greater range of normal emotional and behavioral responses as a result of the unformed nature of the personality. The therapist, therefore, can be more flexible and must anticipate and not be discouraged by seemingly broad swings of emotion and behavior in the course of treatment. The plasticity of the child's personality is also an asset in the working out of a preventive model that heads off disturbing patterns with appropriate intervention prior to the crystallization of the personality.

As unpredictable as adolescents' behavior is to those in their environment, a similar unpredictability exists in the therapeutic relationship. Adolescents entering the therapy situation are characteristically impatient, intolerant, and uncommunicative. They may fail to elaborate on any details of the current situation or difficulties presented. They may deny any responsibility for the current problems, preferring to place blame elsewhere, or may actually have almost no insight into the reasons they have been referred for treatment. Picture a 16-year-old male sitting in your office, slouched in a chair, a cap and long hair covering his averted eyes. His first words and only complete sentence for the next hour are: "I don't want to talk to no f—king shrink." A reflective statement on your part that he must be upset about something only brings a muffled grunt. A series of your best open-ended questions elicits only a series of unelaborated "Yes's," "No's," "I don't know's," "Maybe's," and "It's the damn teachers." Your feeble attempts to introduce humor or to discuss *safe* topics bring only more grunts, a few eye rolls, or no response at all. His posture throughout the seemingly never-ending hour remains essentially unchanged. This initial session represents the base on which you will build your therapeutic relationship with the young man. It is little wonder that many therapists

avoid such interactions. Despite our best rationalizing that the adolescent is reacting to the situation and not to us, it is often difficult to come out of such an unproductive session feeling as though we made progress and that our skills are up to the task of helping the adolescent.

Depending on the level of development and maturity, work with the adolescent may range from gamelike approaches utilized with younger children to therapy that resembles interventions with an adult presenting similar problems. Most adolescents will not be candidates for insight-oriented, in-depth therapy involving the reworking of previous experiences. Goals may range from better self-understanding with some personality reorganization to simple stabilization and improved functioning without major personality change.

Unstructured probing, queries about deep personal feelings, or challenging the adolescents to explain their misbehavior will likely produce further uncooperativeness or yield a strong emotional response. Beginning with factual information in a nonjudgmental manner will help allay initial anxieties. The therapist needs to explain how the relationship will differ from those with parents, teachers, peers, and others. The goal at this level is to achieve engagement with the adolescent and then implant the initial seeds for establishing a motivation. The initial agreement from the adolescent may simply be to return to another session.

The adolescent therapist will be more active in comparison with the adult therapist. Long silences, noncommittal responses, and long periods of formulating answers to the adolescent's concerns should be avoided. Adolescent therapists may find they talk with these clients relatively more than with adult clients. Explaining thoughts explicitly, phrasing questions concretely, and, in general, using a direct approach will facilitate work with the adolescent. Many of the interpretive leads and nondirective probes used with adults may be perceived by the adolescent as trickery and may add to resistance. Therapists need to present themselves as genuine. A spontaneous, conversational approach that is more akin to talking with a casual friend is recommended. The adolescent is likely to be curious about the therapist's "real life," and the therapist's responses to such questions should be matter-of-fact and nonevasive. While not attempting to influence values, the therapist should be willing to share personal opinions and attitudes with the adolescent. Acknowledgment of the adolescent's feelings about various issues and situations is helpful; the therapist should be particularly aware of the current teenage values, fads, slang, and so on, and be sensitive to the pressures related to adolescents' social and emotional developmental levels. The therapist needs to communicate a liking of, and interest in, the adolescent. This is best done indirectly because the adolescent will recognize the artificiality of an "I like you." A sincere commitment to engage with the adolescent in mutual problem solving, along with other concrete gestures and expressions of interest, is most helpful. Finally, the therapist must work at

maintaining a balance along the continuum of independence-dependence. Adolescents should not be treated like children; yet they should not be given signals that they are entirely free to make all of their own life decisions.

INTEGRATION: MULTIMODAL AND MULTISYSTEMIC

This book borrows (and somewhat bastardizes) the term *multimodal* initially introduced by Lazarus (1976) to describe the overall philosophy implicit in the subsequent chapters. Lazarus (2006, 2009) has been refined to some degree with the current model being fairly consistent with cognitive-behavior therapy. Lazarus presented his BASIC ID, an acronym for seven interactive modalities that are investigated as potential points of intervention for problems. The modes are Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal relationships, and Drugs-Diet. This approach presents a comprehensive method of identifying problems and then deciding the most effective way to intervene. Keat (1979, 1990, 1996) expanded on this approach with his own acronym, BASIC IDEAL, by adding E for Educational or school pursuits, A for Adults in the child's life (parents, teachers, relatives), and L for Learn the client's culture.

This book takes a broad view of what is "psychotherapeutic" for a child or an adolescent. By multimodal, we refer to the many types of interventions to help troubled children and adolescents. Kazdin (2000) identified more than 500 terms that have been used in the research and case study literature to describe interventions with children and adolescents. This nearly exhaustive list points to the many interventions we have available to facilitate therapeutic change with children and adolescents. There also exists a range in each alternative. Educational measures, for example, can range from resource room help to a full-time structured placement. Parental interventions may involve parenting classes or perhaps therapy for the parents. In most cases, a multimodal, or combined, approach will be used. For example, children may receive individual therapy, their parents may receive counseling, and the teacher may conduct a behavior management program. Although it is desirable to intervene in the most efficacious and cost-efficient manner, we do not make assumptions that one technique is preferable to or more therapeutic than others. At this point, neither research nor clinical experience is able to identify whether a child with a low self-concept, for example, is helped more by 2 hours a week of individual therapy or by having a teacher who is trained to consistently provide positive successful school experience. We do not know whether group social skills training is more beneficial than family therapy. What we do know is that several types of intervention have some benefit for children and adolescents. The more interventions and systems that can be combined—the more modalities that are involved in the treatment—the more likely it is we will realize our overall therapeutic goals. This approach is not a "let's try everything" plan. It involves careful assessment of

problems, selection of appropriate interventions, and coordination and communication among those providing services. As long as our treatment programs are not excessively costly or time-consuming, interventions involving several modalities are indicated.

This multimodal view also implies two other basic assumptions. First, professionals with a variety of backgrounds are involved in child treatment. A teacher with a bachelor's degree in special education may be working with a child who is receiving individual therapy from a psychiatrist who has completed a child psychiatry fellowship program. A high school guidance counselor may work individually with an adolescent whose family is in therapy with a licensed psychologist. A further assumption here is that a person does not have to be called a therapist to have therapeutic impact on a child. The second, related, assumption involves the settings where treatment takes place. Troubled children and adolescents receive treatment in, among other places, classrooms, schools, agencies, clinics, group homes, and hospitals. In this book, we do not make the artificial distinction between counseling and psychotherapy. We assume that a similar core of principles and techniques can be adapted to many settings. Although the presenting problems may differ depending on the setting, we believe, for example, that a cognitively oriented school counselor will function in a manner relatively similar to a cognitively oriented psychiatrist in an inpatient setting. The overriding concern is the development of effective, coordinated, and multifaceted interventions.

Multisystemic therapy (MST) treatment was originally developed for interventions with antisocial and delinquent youth (Henggeler, Schoenwald, Borduin, & Rowland, 1998). The approach is based on social-ecological theory that includes treatment considerations at the individual, family, peer, school, and community levels. In this perspective, the individual child or adolescent is viewed as at the center of a variety of interacting and interdependent systems. Treatments aimed at these various systems can be done simultaneously and can ultimately impact the individual. All these levels are viewed as potentially contributing to the development of emotional and behavioral problems, as well as to the maintenance of the difficulties. The MST approach also emphasizes treatment in the natural environment.

More recently, MST treatment has expanded to intervene with a broader range of psychological problems (Curtis, Ronan, & Borduin, 2004; Henggeler, Schoenwald, & Rowland, 2002; LaFavor and Randall, 2013; Rowland et al., 2000). Typically, MST has dealt with children and adolescents with more serious and pervasive problems. A number of basic tenets underlie MST:

- Multisystemic therapy seeks to identify risk, protective, and maintaining factors in the natural environments.
- Multisystemic therapy is family-based and shares some of the systemic perspectives of other family therapy approaches. However, MST tends to be more intense

and emphasizes more linkages between the children/adolescents, their family, and other units in the broader natural social network.
- Treatments are goal-based with families having primary input in designation and selection of goals.
- Treatments heavily involve caregivers and aim to alter the networks on a longer term basis for maintenance of gains and changes.
- Treatments emphasize strengths and positives of the clients and their network and work at increasing responsibility across persons in the network.
- Multisystemic therapy has a problem-solving, present, and action-oriented focus.
- Treatments identify sequences between and among units in the network and seek to alter the sequences to facilitate change.

Although the overall theme of this book is on theories, these theories provide options in MST, particularly at the individual, family, group, and school level.

RESEARCH AND EFFICACY

The effectiveness of psychotherapy has been controversial for many years, and this has been particularly notable in the child and adolescent area. The child and adolescent area is confounded/complicated by both developmental factors and systemic and family factors. Attempts to summarize research have been through traditional critical literature reviews with meta-analysis the more contemporary approach.

Historical and Traditional Reviews

Since Eysenck's (1952) classic and much-debated study on the effectiveness of psychotherapy with adults, researchers and clinicians have pondered the question, "Does psychotherapy work?" Eysenck's study, generally recognized as having spawned considerable research in psychotherapy, reviewed a number of studies of psychotherapy outcome with neurotic adults. His evaluation concluded that the percentage of treated clients who improved was not substantially different from the spontaneous remission rate (i.e., those individuals who improved without psychotherapy). He found that roughly two-thirds of each group, treated and untreated, reported improvement. Eysenck concluded that there was little evidence to support the effectiveness of psychotherapy with adult neurotics. Eysenck's data and methodology have been cited, reanalyzed and reinterpreted, and criticized and condemned ever since. Despite its controversial nature, his study is important for the discussion, research, and examination of the therapeutic venture it has fostered.

Systematically and carefully studying the psychotherapy effectiveness question is one of the most difficult research areas in the behavioral sciences. Understanding the process of psychotherapy and its relationship to behavior change is an extremely

complex proposition. The six volumes of the *Handbook of Psychotherapy and Behavior Change* (Bergin & Garfield, 1971, 1994; Garfield & Bergin, 1978, 1986; Lambert, 2004, 2013) point to both the methodological complexity and the enormity of the issues. These volumes have attempted to bring together current empirical knowledge and data on psychotherapy. To utilize current research findings or to attempt research in this area, we must be aware of the problems facing researchers:

- Psychotherapy represents a wide variety of techniques, in some ways preventing a clear, unambiguous definition of psychotherapy.
- Psychotherapy differs depending on the theoretical orientation of the therapist, the length of time of the treatment, and the format (i.e., individual, group, marital, parent, family consultation).
- The clinical definition of client populations may be ambiguous and thus limit generalizability.
- Clear definition of symptomatology and the client characteristics may vary in studies and be somewhat a result of the setting. Would two studies of treatment of anxious children produce similar results if one were conducted in a school and one at a clinic? Similarly, there are subgroups that might be studied separately (e.g., males versus females, Blacks versus Whites, disadvantaged, children).
- Therapists vary in age, sex, training, orientation, competency, style, and personality characteristics. Outcome could be affected by any one of these. Some research has studied the client/therapist match issue (i.e., whether a certain type of therapist works best with a certain type of client).
- Research can focus on process or content variables, or outcome. Process studies examine what goes on in therapy, typically some client/therapist interaction variable. Outcome studies examine whether the person is improved or whether there is behavioral or affective change following intervention. Although some studies attempt to relate process to outcome, both have been and continue to be studied extensively.
- In outcome studies, what represents appropriate measures to gauge *therapeutic change*? Do rating scales, personality tests, client report, therapist rating, or the reports of significant others validly and reliably reflect genuine change? What represents improvement?
- Other methodological issues exist. Are single-subject research designs appropriate for studying the general effectiveness of techniques? What represents an appropriate control group for those who receive treatment? Both those people on waiting lists for treatment and defectors (those who fail to return to the clinic for therapy) have been used in comparison studies. Do these groups represent ones that are clinically comparable to the experimental group?

- Psychotherapy does not occur in isolation. How do we account for other extraneous variables that may affect our results?
- What are the long-term effects of our interventions? Does a 1-year positive follow-up on clients treated for depression mean that these individuals will also suffer fewer problems with depression in the subsequent 5 or 10 years?

Psychotherapy research with children and adolescents presents some special research problems. Levitt (1971), an early critic of psychotherapy with children and adolescents, noted that because the child is a developing organism, many of the symptomatic manifestations of essentially normal children tend to disappear as a function of development. Some problems like temper tantrums, enuresis, specific fears, and sleep disturbance tend to go away in time. Levitt (1971) notes, "There is some reality in the common-sense notion that children 'grow out' of certain behavior problems" (p. 477). This makes it difficult to sort out the effects of therapy versus the effects of maturation. Similarly, some problems that are indicative of underlying emotional disturbance may disappear as a function of development yet reappear in another form that Levitt calls "developmental symptom substitution" (p. 477). For example, a child successfully treated for enuresis at 8 years of age might be classified, for research purposes, as "cured" or "improved" yet present serious problems as an adolescent. Extending this view somewhat, research on the effects of childhood psychological treatment on later adult adjustment is difficult to do, yet this issue is an important one. Levitt also notes that, although the child may be the identified patient in clinical studies, persons other than the child may actually be the direct focus of treatment, thus making the isolation of treatment effects difficult.

In reviewing psychotherapy research studies, we are left with certain impressions. Because of the difficulty in conducting research in this area, it is possible to critically examine almost any single study and dismiss its results or offer alternative explanations of the findings on methodological grounds. The orthodox experimental psychologist who spends the day in a rat laboratory might smirk at some of our research conclusions. But because we work with humans who have difficulties in living and because the alleviation of these difficulties is a complex process, we must take a somewhat softer view of the research. We must examine the literature with the understanding that few, if any, studies are going to answer absolutely the question, "Does psychotherapy work?" Rather, we must continue to critically examine the data and conclusions and to glean from the research those implications that relate most directly to our clinical work. This proposal is made not to support sloppy research or blanket acceptance or rejection of findings but to support a flexible and open-minded view of the current literature and status of the psychotherapy venture.

The effectiveness of psychotherapy with children has been chronicled in reviews by Levitt in 1957, 1963, and 1971, and in a review by Barrett, Hampe, and Miller in 1978.

Levitt's 1957 study was modeled after Eysenck's (1952) study of the effectiveness of adult psychotherapy. Surveying reports of evaluation at both the close of therapy and at follow-up and comparing them with similar evaluations of untreated children, Levitt found that two-thirds of the evaluations at close and three-fourths at follow-up showed improvement. Roughly the same percentages were found in the untreated control groups. Levitt wrote: "It now appears that Eysenck's conclusion concerning the data for adult psychotherapy is applicable to children as well; the results do not support the hypothesis that recovery from neurotic disorder is facilitated by psychotherapy" (p. 193). Levitt noted, however, that his evaluation "does not prove that psychotherapy (with children) is futile" (p. 194) and recommended "a cautious, tongue-in-cheek attitude toward child psychotherapy" (p. 194) until additional evidence became available. The 1963 study utilizes a similar methodology and again concluded that the hypothesis that psychotherapy facilitated recovery from emotional problems could not be supported. Some of the 1963 data did suggest that comparisons should be made in diagnostic categories. Levitt also found that improvement rates tended to be lowest for cases of antisocial acting out and delinquency and highest for identifiable behavioral symptoms like enuresis and school phobia. The 1971 review departed slightly from the previous reviews and looked at a wider range of modalities than just child psychopathology. These included the effects of inpatient versus outpatient treatment, drug therapy, type of special class placement, and the use of mothers as therapists. Although individual studies showed some effectiveness, the overall conclusion again pointed to a lack of proof that these interventions are generally helpful. Levitt (1971) also focused on two identifiable diagnostic classifications, juvenile delinquency and school phobia, for further examination. School phobia tended to respond favorably to treatment, but Levitt questioned whether treatment was simply removing the symptoms of more serious underlying core problems that would surface in some other form later. Conventional psychotherapy with delinquents appeared to be generally ineffective, but some moderately positive results were found in examining more comprehensive treatment programs for delinquents. In addition to still questioning the effectiveness of child psychotherapy, Levitt was able to provide some preliminary conclusions. He noted that many of the principles on which traditional psychoanalytically based child guidance treatment have been based are now being challenged by research. The evidence at that time did not support the necessity of involving the mother in treatment, the relative insignificance of father involvement, the relationship of outcome to intensity of treatment, the desirability of encouraging the expression of negative feeling, ignoring undesirable behavior, or the notion that the home or family situation is likely to be more therapeutic than other child-care settings. In other words, many principles that had guided, and probably still do guide, much of traditional child treatment simply are not supported in the research. Rigid orthodoxies are not empirically supported, although few of the innovative treatments are definitely supported either. Levitt called

for more studies of treatment of specific diagnostic classifications and more long-range follow-up studies.

Two other reviews of treatment bear mentioning. First, Abramowitz (1976) reviewed efficacy studies of group psychotherapy with children, reaching a conclusion similar to the reviews of individual therapy. Definitive conclusions are not possible at this point, and, based on available data, favorable responses to group therapy are not indicated. However, if a group therapy approach is indicated, the feasibility of using a behavioral approach might be considered first. Second, Tramontana (1980) has reviewed psychotherapy outcome research with adolescents and offered conclusions not much different from other reviews. Noting a sparseness in the adolescent literature, Tramontana (1980) found no clear evidence of effectiveness but found the area to be fraught with research methodology problems.

Thus, through the 1980s, the dominant research conclusion was that psychotherapy was not effective with children and adolescents. Weisz, Doss, and Hawley (2005) reviewed 40 (1962 to 2002) years of research on psychotherapy for child and adolescent mental health problems. Their review was intended to both summarize and critique the knowledge base. They concluded that these initial conclusions about effectiveness had a number of problems in the existing research. Among these problems were poorly defined theoretical perspectives, few randomized clinical studies, poor descriptions of sample characteristics (including diagnoses), most studies not detailing ethnicity or racial characteristics, small sample sizes, and poorly defined treatment targets.

Weisz et al. (2005) noted some progress methodologically more toward the end of the period they studied. Yet, they felt the conclusion of earlier researchers regarding the ineffectiveness of child/adolescent psychotherapy was not warranted.

Meta-Analyses

The reviews previously noted could all be classified as evaluating the child psychotherapy research literature through the traditional critical literature review approach. The systematic approach of meta-analysis is now the standard for summarizing psychotherapy research. This approach combines the results of efficacy studies by evaluating the magnitude of the effect of treatments. Smith and Glass (1977) popularized this statistical approach in the psychotherapy literature. In a meta-analysis, each outcome result in a controlled study is treated as one unit of magnitude of effect or *effect size* (ES). The effect size is calculated by subtracting the mean of the control group (M_c) from the mean of the treated group (M_t) and then dividing the difference by the standard deviation of the control group (SD_c): $ES = M_t - M_c/SD_c$. The effect sizes are averaged to determine average effects across and between treatments. The effect size is a standard score that indicates how many standard deviation units a treatment group differs from an untreated control group. A positive effect size indicates improvement or the beneficial

effects of treatment. For example, an effect size of 1.00 indicates that untreated subjects at the mean of their group (i.e., the 50th percentile) would be expected, on average, to rise to the 84th percentile (i.e., a one standard deviation improvement) with treatment. Evaluating across all types of counseling and psychotherapy, Smith and Glass (1977) found an average effect size of .68.

Cohen (1988) proposed guidelines for interpreting effect sizes: a "small" effect size is .20, a "medium" effect size is .50, and a "large" effect size is .80. Cohen noted, however, these guidelines may be different for each field of study.

As the meta-analytic approach has evolved, many meta-analyses have been completed on the effectiveness of child/adolescent counseling and psychotherapy. Casey and Berman (1985) analyzed studies done with primarily younger children (under age 13) who received some form of psychotherapy, while Prout and DeMartino (1986) evaluated studies of children and adolescents who received interventions for school-based or school-related problems. Respectively, they found effect sizes across treatments of .71 and .58. These overall effect sizes are generally consistent with the meta-analyses done primarily with adult subjects. Using a model for evaluating the relative size of treatment effects proposed by Cohen (1988), these effect sizes fall into the "moderate" effect size category. The importance of some of these initial meta-analyses was best summarized by Casey and Berman (1985). Despite some shortcomings in the diagnostic and methodological areas, they felt that the available outcome studies demonstrated the efficacy of treatment across a range of therapeutic approaches and problems. Specifically, they noted: "Clinicians and researchers need not be hesitant in defending the merits of psychotherapy with children" (p. 397).

Since those initial meta-analyses, there have been numerous studies focusing on both the general effectiveness of child/adolescent psychotherapies as well as studies on specific approaches (e.g., cognitive-behavior therapy [CBT]) and for specific disorders (e.g., depression). A summary of all these studies is beyond the scope of this chapter. Two recent reviews summarize the current state of the research. Zirkelback and Reese (2011) reviewed a number of broad-based meta-analyses conducted between 1985 and 2006. Effect sizes ranged from .30 to .97, with most falling into the "medium" range of effectiveness. Zirkelback and Reese (2011) concluded, noting effect sizes averaging around .70 (+/–), that a treated child or adolescent is generally better off than a child not provided treatment. Weisz (2014) examined some of the same meta-analyses and found a similar range and typical effect size, but cautioned about the generalizability across contexts (e.g., disorders, settings).

In the first edition of this book, we noted that the outcome research on child and adolescent psychotherapy left us with an unclear and confusing impression (Prout, 1983). The available reviews at the time did not support effectiveness, nor did they prove the ineffectiveness of child/adolescent therapeutic interventions. Yet, at the same

time, they pointed to the complexity of the issue and the methodological problems in conducting research in this area. Although there remain some unresolved questions concerning the efficacy of child and adolescent therapeutic interventions, the array of meta-analyses present systematic reviews indicating some degree of benefit to these interventions. The question of effectiveness is more clearly answered at this point. Further, data appear to support the greater efficacy of certain types of interventions, notably those falling in the broad category of cognitive-behavioral interventions. There is now support that therapeutic interventions with children and adolescents are a viable clinical activity. Nonetheless, we continue to recommend a cautious, thoughtful, and examining approach to child and adolescent treatment.

THE ROLE OF EVIDENCE IN PRACTICE

As the practice of counseling and psychotherapy has evolved, there has been increasing evidence from both within and beyond the mental health professions that our interventions and treatments are beneficial. Two perspectives address this issue. First is *evidence-based practice*, which is associated with empirically supported treatments. The second is often called *practice-based* evidence, which examines the role of client/patient feedback in the therapeutic process. Although there has been some controversy comparing the approaches, we feel that they are not incompatible with one another.

Empirically Supported Treatments

Although there are different definitions of empirically supported treatments (ESTs), these treatments generally refer to therapies that have been evaluated in a randomized control study, have clearly defined treatment targets and/or diagnoses, have a clearly established treatment protocol (e.g., a treatment manual) that can be replicated, have shown significant treatment outcome benefits, and have been shown to be effective in more than one study (http://www.div12.org/empirically-supported-treatments). The Society of Clinical Psychology maintains the website that summarizes the current status of treatment in several areas (http://www.div12.org/empirically-supported-treatments). Sources of information specifically dealing with children and adolescent include *Evidence-Based Psychotherapies for Children and Adolescents* (Weisz & Kazdin, 2010) and *Treatments that Work with Children: Empirically Supported Strategies for Managing Childhood Problems* (Christophersen & Vansoyoc, 2013).

The EST approach has become very prominent in recent years. It has been criticized for being perhaps too narrow in dealing with actual problems in practice. Notably, the EST approach is typically tied to a specific disorder or problem. In practice, children and adolescents often present with multiple problems (e.g., an adolescent with a conduct

disorder and depression) or comorbidity. Additionally, there still remains large gaps in the child/adolescent EST literature; that is, some problems do not yet have an associated EST or the EST literature does not match the child characteristics or treatment context.

Practice-Based Evidence

Practice-based evidence is associated with the use of systematic feedback and monitoring of client/patient status during the course of treatment. Duncan (2013) argues that the relationship aspects of therapy remain integral to effectiveness and that the relationship is enhanced by soliciting feedback from the client/patient, with collaborative monitoring of outcome. Duncan feels that this process is one of the core ingredients to therapeutic progress regardless of therapeutic approach.

The systematic monitoring of progress is typically on a session-by-session basis. The child/adolescent therapist has options in two well-developed and tested progress monitoring approaches. Duncan and his colleagues have developed various versions of the Outcome Rating Scale (ORS), initially developing an adult version (Miller, Duncan, Brown, Sparks, & Claud, 2003) and followed by child versions (Duncan, Sparks, Miller, Bohanske & Claud, 2006). These scales are brief visual analogue self-report ratings of general status and well-being. More detailed information on these scales can be found at https://heartandsoulofchange.com. Similarly, Lambert and his colleagues (Burlingame, Wells, Lambert, & Cox, 2004) developed youth versions of outcome questionnaires (OQ) modeled after adult versions of their outcome measures. The youth versions include questionnaires for parent and youth. Information on the OQ measures can be found at (http://www.oqmeasures.com). Both the ORS and OQ approaches are designed to be completed quickly and are a regular part of ongoing treatment.

CONCLUSION

This chapter has provided an overview of the broad area of the psychological treatment of children and adolescents. Many issues are important to those who do clinical work with children. The mental health needs of children create enormous demands that the social services and mental health delivery system have not yet even closely met. The child/adolescent therapist must be aware of developmental factors and plan and conduct treatment accordingly. Further, the therapist must be aware of the unique aspects of the therapeutic relationship with children and adolescents. A multimodal, combined approach to treatment is advocated, necessitating a broad view of what may potentially be therapeutic for the child/adolescent client. Finally, the question of efficacy has become somewhat less debatable since the earlier editions of this book. There is now moderate but clear support for the general effectiveness of child and adolescent

therapeutic interventions although the evolving literature and research base continue to point to the complexity of the issue. The professional has expanded options with evidence-based practice and practice-based evidence strategies.

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CHAPTER

2

Ethical and Legal Issues in Psychological Interventions with Children and Adolescents

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The practice of child therapy has been in existence for several decades but, unlike its adult counterpart, has had historically less research, development, and classification systems designed specifically for it. The *Diagnostic and Statistical Manual* (*DSM-5*; American Psychiatric Association, 2013) is comprised primarily of adult diagnostic categories that have been applied to children and adolescents. Although more emphasis has been placed on children and youth with the most recent revision, empirically based information continues to be lacking for individuals under the age of 18. Although this has changed in the past 10 years, the field of child therapy generally continues to lack a sufficient body of empirically based research related to diagnosis and interventions, in both therapeutic and psychopharmacological areas, as well as coordination of both types of interventions. According to Mash and Dozois (2003), the knowledge base for children and adolescents is often comprised by the fragmented and unsystematic methods that have been used as well as the difficulties inherent in research with children and adolescents. Similarly, the professional ethical and legal considerations, as they pertain to therapy services for children, have also been limited. Yet the Surgeon General Reports that 20% of children and adolescents will experience mental health problems and that approximately 10% to 15% of school-aged youth are functionally impaired due to mental illness (U.S. Department of Health and Human Services [USDHHS], 2012). The deleterious effects of mental health on children and adolescent's academic performance and

social-emotional development have been well documented (Doll & Cummings, 2008). Thus, it is imperative that professionals providing services to children and youth be knowledgeable of both ethical and legal issues. Although the historical emphasis has been primarily in adult psychotherapy and the therapist's role in relation to the adult client, different issues arise, both ethically and legally, when children are the recipients of therapeutic interventions. Ross (1980, p. 62) succinctly categorized the issues with children: "The ethical implications of treating an individual's psychological problems increase in magnitude as an inverse function of that individual's freedom of choice."

Ethical considerations, by nature, do not have to be and often are not simple or straightforward. Nor do ethical considerations have black-and-white solutions; yet they are nonetheless critical to child clinicians and mental health service providers. It is important that therapists understand their role as it pertains to children's legal rights as well as the ramifications, both negative and positive, of therapeutic interventions with minors. Parental legal rights and the child's role in the family and a school setting are also ethical areas that need to be considered when providing services to a child. There are times that *Ethics* may require a higher standard of behavior than the current policies and pertinent laws (National Association of School Psychologists [NASP], 2010; National Association of Social Workers [NASW], 2008). Ethical behaviors are related to those involving general professional competency, professional relationships, students, parents, legal guardians or surrogates, community, and school psychology trainees and interns.

The purpose of this chapter is to discuss the legal and ethical considerations involved with the provision of therapeutic services to children and adolescents. A brief review of general ethical principles is followed by a discussion of special considerations in working with child/adolescent populations. Legal issues related to definitions of treatment, confidentiality and privileged communication, informed consent, records and privacy, and special considerations in schools are discussed. Legal cases and precedent are also presented to provide a historical overview of ethical issues.

ETHICAL ISSUES

Virtually all human service, educational, and medical associations have an ethical code or set of ethical principles to guide the professional behavior of their practitioners. These codes provide a basis and reference point for decision making in general case situations as well as crisis situations (Jacob & Hartshorne, 2011). The NASP (2010, p. 1) states that ethics are the "formal principles that elucidate the proper conduct of a professional school psychologist" and additionally that at times ethics "may require a more stringent standard of conduct than law" (p. 2). These codes or principles are not legally binding, although their foci may overlap with some statutes. This is perhaps one of the major distinctions between ethical and legal principles. A violation of an ethical principle,

when a related statute does not exist, can result in censure, probation, or expulsion by the respective professional organization. Evidence of unethical practice may support documentation in a legal case, but by itself has consequences related only to the professional organization.

The ethical guidelines of the major helping service professions (e.g., American Counseling Association [ACA], 2014; American Psychological Association [APA], 2002; American School Counselor Association [ASCA], 2010; NASP, 2010; National Association of Social Workers [NASW], 2008) provide codes that, in part, relate to ethical considerations in conducting psychological interventions with children and adolescents. Numerous similarities and consistent themes across these sets of ethical principles are noted. Additionally, many of these principles are interrelated. Some general themes that are relevant to the practice of child/adolescent therapy are reviewed in this chapter. Specific sets of ethical guidelines also exist for each discipline and are available on each organization's website.

The following section provides an overview of several ethical principles related to therapeutic intervention with children and adolescents, particularly counseling. Not all the ethical principles of the pertinent associations can be presented here. The principles reviewed here include responsibility and client welfare, confidentiality, parent notification or involvement, professional relationships, competence, public statements and presentations, and private practice or school issues. When working with children, depending on the setting, it can be assumed that the *client* can include a child, parents or guardians, teachers, additional school personnel, supervisors, and trainees (NASP, 2010). According to Smith (2003), although the way to avoid ethical problems is for a professional to evaluate a situation for probable or possible conflicts and discuss them in advance with colleagues and the student and parents, all ethical quandaries cannot be predicted. Professional self-evaluation of the appropriateness and effectiveness of the services provided is important. The NASP (2010, p. 2) in the *Principles for Professional Ethics* states that school psychologists act as advocates for all students and are "committed to the application of their professional expertise for the purpose of promoting improvement in the quality of life for students, families, and school communities."

The ideas of *responsibility* and *client welfare* refer to professionals assuming responsibility for their position of influence with clients and recognizing the consequences of their actions and professional activities. In doing so, they promote foremost the welfare of their client(s). With regard to psychological interventions, professionals must use techniques that have the likelihood of promoting therapeutic gain based on empirical research findings in their clients and accept the responsibility of the consequences/results/changes from using these techniques. Professionals should avoid conflicts of interest about their clients, clarifying allegiances between their clients, employers, agencies, and other persons directly involved (ASCA, 2010). Clients should

be fully informed about the services offered by the professional as well as any changes to a treatment plan that are experimental (APA, 2002; Standard 10.01b). When a client is clearly not benefiting from services, the professional should alter or terminate the therapeutic relationship. When providing services to a child or adolescent under the age of 18, the parents or guardian, in addition to the student, must be fully informed about the intervention and expected outcomes. Practitioners have the ethical responsibility to use techniques that respect the dignity and autonomy of the child (Jacob & Hartshorne, 2011), which should include an explanation of the nature of the intervention, whether there is a choice in participating, and a discussion of confidentiality when the child reaches school age. Although the objective of a therapeutic, counseling relationship is to alleviate a student's difficulties through continuous, planned interactions and/or by facilitating change in the student's environment, most often school or home, it is important for professionals working in both clinical and school settings to remember that a primary responsibility, when working with children and adolescents, is to protect them from harm. A school psychologist has the ethical responsibility to function as a child advocate, with their primary responsibility lying with protecting the rights and welfare of the child (NASP, 2010).

Professionals have the responsibility to protect the *confidentiality* of information gathered in the context of a therapeutic relationship. The ethical principle of confidentiality should be distinguished from the legal concept of confidentiality, which is discussed later in this chapter. Information should be released only with the permission of the client, with special provisions to protect those clients who cannot give informed consent. Professional cases should be discussed only with directly concerned colleagues. This information and the client's identity should be disguised if it is used in other contexts (e.g., teaching, training, case examples), or the client's consent should be obtained. Confidentiality also relates to the proper maintenance, storage, and disposal of notes or records of counseling or therapeutic interventions (ACA, 2014; APA, 2010; ASCA, 2010; NASP, 2010; NASW, 2008). The most recent APA ethics code (2002) removes the prohibition against releasing test information to persons who are not qualified to interpret the raw test data. According to the 2002 Code of Ethics, psychologists must release test data to clients (or to their parents if under age 18) and their designee when a written release of the records is provided (Smith, 2003). Without a written request for records, test data is released only with a court order or in accordance with the law. According to Smith, the 2002 APA code does allow psychologists to withhold test data when necessary to protect them from substantial harm or misuse or interpretation of the data or the test. However, caution is suggested when withholding this information because the Health Insurance Portability and Accountability Act (HIPAA) does not recognize misinterpretation or use of tests as a valid reason to withhold medical records (Smith, 2003). An additional change to the 2002 ethics code of the APA is the

definition of the terms *test data* and *test materials*. Test data are considered to be "raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recording concerning client/patient statements and behavior during examination" in addition to "portions of test materials that include client/patient responses." Test materials are defined as "manuals, instruments, protocols, and test questions or stimuli" and don't include test data (APA, 2002, p. 14; Section 9.04).

Issues related to *professional relationships* involve relationships with colleagues, clients, and other concerned parties. Professionals should develop and maintain relationships with other colleagues in the human service area. They should be aware of the traditions and practices of those in other professional disciplines and groups to cooperate with and use the resources of these other professionals. Therapeutic services should not be offered to a client who is receiving services from another professional. However, at times a child or adolescent may be receiving services from a mental health agency or private provider outside the school, and seeing a school-based professional, such as guidance counselor, school psychologist, or school social worker, for problems more specifically occurring in the school setting, such as anger control or peer interaction difficulties. It is imperative that release of information or consent forms be obtained from the parent or guardian to facilitate communication and coordination of services between both the community and school-based professionals to ensure that the most appropriate services are provided to the child or adolescent. Professionals should be aware that multiple parties may be concerned about the welfare of a client. Again, allegiances of the professional should be clarified. Communication between professionals related to treatment of the child or adolescent is critical and should be obtained through parent or guardian consent if the youth is under the age of 18. An additional professional relationship concern that may arise is related to ethical violations by another psychologist or mental health provider. According to the APA (2002, p. 4; Section 1.04) ethics code, "an attempt to resolve the issue by the concern should be bringing it to the attention of the individual, if informal resolution appears appropriate and intervention does not violate confidentiality rights that may be involved." If an informal resolution is not obtained, further action should be taken, such as referral to ethics committees at the state or national level or state licensing boards (APA, 2002, p. 4; Section 1.05).

Professionals are obligated to practice within the limits of their *competence*. They should recognize the limits of their skills, the techniques they utilize, and the range of clinical problems they are equipped to deal with therapeutically. They should function within the sphere of their education, training, and professional experiences and accurately present their qualifications and backgrounds to clients. In conjunction with this ethic, it is incumbent on professionals to participate in continuing education and other forms of professional development to maintain and improve their level of competency. This is particularly relevant for professionals practicing in a school setting,

where expertise in a large number of areas, such as autism, attention-deficit/hyperactivity disorder (ADHD), preschool mental health, elective or selective mutism, mental health issues related to cultural and linguistic diversity, eating disorders, bipolar disorder, and self-injurious behaviors such as cutting, is expected. It is critical that school psychologists, social workers, and counselors receive specific training in these areas and are familiar with the research related to a specific problem of a child or adolescent. Although it is not realistic to expect professionals to be experts in all areas, especially for professionals just beginning their career, requesting ongoing assistance from an expert in a particular area, such as autism, or referring the student to another specifically trained professional is ethically necessary. If personal problems, personal conflicts, or other factors interfere with their therapeutic effectiveness and competence, therapists should take steps to protect their clients' welfare. This is particularly important when working with children or adolescents and families from culturally and linguistically diverse backgrounds. It is important for mental health providers to be not only knowledgeable but also aware of their limitations. For example, although school psychologists may be knowledgeable about Arabic cultures through readings, professional development activities, and so on, it does not indicate that they are competent to provide mental health services to the student, particularly when other professionals may be able to provide more appropriate interventions. Similarly, when working with a student with substance abuse issues, general knowledge of abuse does not indicate the skills needed to be a successful therapist for the student unless specific coursework or other education has provided this training. When mental health providers are aware that they are not the best service provider for a child or adolescent, it is important to explain this clearly to the child and parents or guardians and to provide appropriate referral sources.

Issues related to *public statements and presentations* concern the presentation of materials in advertising, public lectures, and the print and electronic media. Announcements of services should present accurate, factual information about professional background and services and should avoid testimonials or guarantees. Public presentations about psychological topics should focus on scientifically accurate information. Therapeutic and other professional services should not be conducted in a public forum, but rather in the context of a professional relationship.

The proliferation of professionals in *private practice* presents some provoking problems. These practitioners should fully inform their clients about financial requirements and considerations in these relationships at the beginning of services. If also employed in another institution, it is unethical to use your institutional affiliation to solicit clients. For example, school social workers or psychologists who have a private practice in addition to school employment cannot solicit clients from schools in which they are assigned. It is also questionable whether a school employee in private practice should accept clients from the school district, which can be particularly problematic in small districts

and communities. In some situations, clients must be informed of services available through public institutions (e.g., schools). The APA (2002) ethics code specifically defines multiple relationships, which was not done in previous codes, and also states that not all multiple relationships are unethical (Standard 3.05). Specifically, according to the ethics code (Smith, 2003), psychologists should avoid relationships that could negatively impact their professional performance or harm/exploit the other person. Multiple relationships that are not expected to have these effects are not unethical. It may be impossible for a psychologist to completely avoid such relationships, and according to Gottlieb's (2003) reflection about the impact of three factor's may facilitate identification of unethical multiple relationships. The three factors are:

1. *Power*: The power differential between the psychologist and the other person, whether it is a therapist/client or supervisor/trainee relationship.
2. *Duration*: Is the relationship to be long term or episodic/brief?
3. *Termination*: Does the client/parent understand that therapy is terminated or is it a chronic problem that requires intermittent therapy over a long time period?

The latter may preclude any relationship outside of one that is therapeutic in nature. A sexual relationship with a client is always an ethical violation. Multiple relationships when working with children often involve relationships with parents or guardians, such as coaching sports teams or leading Boy or Girl Scout troops. The impact on the therapeutic relationship with the child through a relationship with family members should be paramount in decision making regarding the ethics of a situation. However, it is not automatically an ethical violation to participate in activities with your child, such as Boy or Girl Scouts, when a client is also on the team. Questions related to the previous factors should be asked to clarify a possibly conflictual relationship, and extreme caution should be made to avoid personal or treatment conversations outside the therapeutic or school setting.

Ethical violations are classified by the specific principle and section(s) of principles found to have been violated. In terms of actual adjudicated complaints, the largest numbers of violations involved the principles of dual relationships, adherence to professional standards, governmental laws and institutional regulations, and confidentiality. The term *dual relationships* refers to any relationship a psychologist might have with a client that might impair professional judgment and/or present the risk of exploitation. This could include the assessment and treatment of friends, relatives, or employees, as well as sexually intimate relationships with clients. The majority of complaints in this area dealt with psychologists being sexually involved with their clients. Complaints regarding adherence to standards, laws, and regulations most often dealt with violation of a law or other formal legal (civil or criminal) adjudication. In particular,

psychologists have had problems related to fee policies and practices, mostly involving fraudulent third-party billing practices. Problems in confidentiality have involved both breaking confidentiality in violation of the law *and* refusing to break confidentiality where required by law, as in the case of mandated reporting of child abuse. Failure to follow informed consent procedures has posed problems in this area.

Another area that is of critical ethical importance when working with children and adolescents is the role of the parent and/or guardian. Jacob and Hartshorne (2011) report that professional codes of ethics and law are consistent in the area of parental consent for youth under the age of 18 when contact with a student is beyond the typical school occurrence and may involve personal and family privacy issues. However, provision of emergency services, such as suicide assessment or a report of possible abuse, may be provided without parental consent (NASP, 2010). However, parent notification immediately after the student emergency contact is important. The exception would be in the case of suspected abuse when a child welfare or protective agency tells the school professional not to contact the parent until the student can be interviewed. In the case of suicide or threats toward others, parent notification and provision of referral sources is critical. Continued therapeutic contact with a student requires parent consent. With the incorporation of student assistance teams or prereferral teams at the school level as well as response to intervention in the reauthorization of IDEA (Individuals with Disabilities Education Improvement Act, 2004), the question of school psychologists' participation with students without specific consent of parent or guardian becomes more critical. Often, a school psychologist is a member of the intervention team and is an integral part of designing prereferral interventions for a child prior to referral for special education consideration. Interventions may range from indirect services to children (teacher and/or parent consultation) to direct services such as classroom observations with the purpose of developing an intervention plan, often related to behavioral and social-emotional issues, and counseling. The objective of the direct services is specifically targeted interventions for a particular child, not the class of students as a whole. Reschly and Bersoff (1999) suggest that parental consent is needed and desired if the focus of the consultation is a specific student and the outcome of the consultation or intervention is that the child may be treated differently from others. Ethically, school psychologists are obligated to ensure that replacement behaviors that result from an intervention, counseling, or consultation are beneficial to the child, not only the classroom teacher, in that they assist in developing long-term appropriate self-management skills to replace inappropriate behaviors that interfere with learning and interactions with others (Jacob & Hartshorne, 2011). Interventions that have the greatest likelihood of success and that are the least drastic procedures with the fewest adverse effects should be selected. Whenever a student is referred to a student assistance team, due to teacher concerns, the parent should be informed of the meeting in advance, the purpose of the meeting, and the

concerns specified, as well as given an opportunity to attend the meeting and identify the team members. An explanation of possible outcomes, such as classroom observations, development of an intervention plan, and so on, should also be provided. Generally, this would be completed by the people making the referral to the student assistance team because they would have the most specific information. A formal letter mailed to the parent or guardian containing the same information is also considered to be best practice, as well as a follow-up telephone contact and letter by a team member specifying the interventions. The ethical and legal question arises with respect to school psychologists involvement following an intervention team, such as whether parent notification of the meeting purpose, possible outcomes, and team members signifies tacit parent consent or if written parental consent is necessary. Generally, parent concerns will often be identified prior to the intervention team meeting when informed of the meeting. Written parent consent for participation of a school psychologist in specific student interventions is suggested. A telephone contact or meeting with parents following an intervention team meeting by the psychologist is necessary to establish a relationship with the parents. An exception to this would be when the parent is in attendance at the meeting and written permission is obtained at that time. An exception to the need for separate parental consent is when psychological interventions, such as counseling, collaboration, and so on are written into the student's individual education plan (IEP).

Special Considerations with Children and Adolescents

There are several ethical considerations with which all individuals in the helping professions must be concerned. However, there are also issues that are specific to those who provide services to children and adolescents. These issues include client identification (i.e., child, parent/family, agency/school) and concomitant therapist responsibilities, child and parental rights, confidentiality, and general professional ethics with respect to service delivery and retraining.

Client Identification

A major issue confronting child/adolescent therapists is identification of the client, whether this is the child, the parent(s), and in the case of educational personnel, the school. Ideally, there is minimal if any conflict between the triad or any combination of it.

According to the ethical principles of the ASCA (2014) and NASP (2010), the student is the primary client. It is, therefore, the responsibility of the counselor or school psychologist to place the needs and rights of the child as the client first. However, it cannot always be assumed that professionals are necessarily child advocates or that they automatically recommend what is most appropriate for the child (Koocher & Keith-Spiegel, 1990). Koocher and Keith-Spiegel further state that a therapist is

morally obligated to serve as a child advocate because children cannot serve as their own advocate due to psychological and physical immaturity or legal statute.

In theory, it makes sense that a clinician would relegate the child to the role of client, but because it is the child who is being treated, practically and legally the role of the parent must also be considered. Because parents have legal responsibility for the well-being of their children under the age of 18 according to most state statutes, therapists have a responsibility to the parents. However, this factor can be confusing and conflictual at times for the service provider. Most often, parents are the primary referral agents for their child, and children frequently become involved in therapy because of parental referral. Although students, particularly those at the elementary school level, do not often self-refer for counseling, this practice is becoming more prevalent, particularly for school counselors at the secondary level, because many referrals for counseling are now student initiated (Jacob & Hartshorne, 2011). This then becomes more of an ethical issue for the school psychologist because legal precedents are not known at this time. Jacob and Hartshorne (2011) recommend that schools adopt written policies that state that students may be seen by school-based mental health professionals without parental consent to determine that a child is not a danger to self or others. According to Koocher and Keith-Spiegel (1990), therapists infrequently refuse to consider children as a client at the onset based on their unwillingness to participate. Therefore, an agreement of sorts has been made with the parents, regardless of the child's wishes, which identifies the parent(s) as also having some client characteristics. Parental input is also critical to the therapeutic process concerning background information, problem identification, and goal setting.

Koocher and Keith-Spiegel (1990) raise the issue of whether parental rights are stymied when a child refuses treatment and a therapist accepts this decision. Several factors should be considered by a therapist when making this decision. The NASP (2010) code states that school psychologists should make every effort to obtain children's voluntary participation in therapy, but should also respect their rights. According to Johnson, Rasbury, and Siegel (1997), the specific factors to be considered are age, level of cognitive development of the child, the child's degree of disturbance, the degree of disturbance noted in the parents, and the degree to which the therapist feels that treatment is warranted. The younger the child's age, the greater the responsibility a therapist has to the parents.

Another potential client is the agency, particularly when counseling a child in a school setting. Because many school psychologists, counselors, and social workers have been hired by educational agencies to provide therapy and counseling services to children in the schools, they have subsequent employer responsibilities. According

to Huey (1986), acceptance of a position in an educational setting implies general agreement with the institution's objectives and principles. He further states that a mental health provider should not be perceived as more concerned with school rules than child rights, but rather with seeking solutions to protect these rights in addition to advocating for school policies to further them. Parental rights are seen as a third part of the triad of child and school, in which a cooperative relationship among the three is critical, albeit difficult, conflictual, and ambiguous at times. However, Huey (1986) sees ambiguity and ethical conflicts among the triad components as an inherent part of the school counselor or psychologist's role. It is a role that requires professional decision making based on ethical values and legal restraints in conjunction with a willingness to accept responsibility for judgments made concerning a child.

Child and Parental Rights

The majority of the literature that discusses child and parental rights emphasizes that both are to be considered clients, but that it is the primary responsibility of the therapist to protect the rights of the child (Koocher & Keith-Siegel, 1990; NASP, 2010). This statement of ethical values provides what on the surface is an appropriate goal. In reality, however, it is not necessarily easily obtained or specific. According to Jacob and Hartshorne (2011), when a child is enrolled in an educational setting, legally, parents need to provide informed consent for psychological services. However, when allowing a student the opportunity to participate in counseling or to refuse services, several factors need to be considered, such as legal precedents, ethical factors, and the student's competency in decision making (i.e., level of cognitive abilities, social-emotional functioning). When protecting the rights of parents and children, the therapist must be careful not to allow personal beliefs to interfere, but rather to assist clients in making appropriate decisions (Huey, 1986). At times, particularly with respect to school-aged students, the client is both the student and the parent or guardian and it is critical to clearly explain the parameters of confidentiality. When a student is seen in a school setting, confidentiality also concerns the information that is shared with teachers and other school personnel. Both students and parents should be clearly informed about confidentiality. Although parent permission for ongoing services provided by a school psychologist is needed, Remley and Herlihy (2001) state that school counselors are able to provide counseling services to students without parental permission when there are no federal or state laws specifically prohibiting this. However, Welfel (2002) suggests that ethically school counselors should obtain both student and parent permission when counseling is likely to involve several sessions. School counselors, as well as school psychologists, have ethical obligations to uphold both parental and student rights.

Over time, authors in the ethics literature (Huey, 1986; Jacob & Hartshorne, 2011; Koocher & Keith-Siegel, 1990; Ross, 1980; Simmonds, 1976) describe key rights for children and parents, as summarized in the following:

Children in Therapy Have the Right:

- To be informed about the evaluation process and reasons and results in understandable terms.
- To be informed about therapeutic interventions and rationale in understandable terms.
- To be informed about confidentiality and its limitations.
- To control release of information.
- Not to be involved in therapy if uncomfortable or unsuccessful (this is not always possible when it is mandated by court order or IEP).
- To be treated with respect and told the truth.
- To participate with the therapist and/or parent(s) in decision making and goal setting.
- Not to be labeled the scapegoat in a dysfunctional family.

Parents' Rights and Responsibilities Include:

- The legal responsibility to provide for their child's welfare.
- The right to access to information (educational, medical, therapeutic) that pertains to their child's welfare.
- The right to seek therapy and/or treatment services for their child.
- The right to be involved in therapeutic decision making and goal setting for their child.
- The right to give permission for treatments.
- The right to release confidential information concerning their child.

It is evident from these lists of child and parental rights that there is overlap and interface between the two. The parental rights mentioned are for the most part also legal rights, unless legal guardianship has been removed by the courts. However, several of the child's rights are ethical values and not mandated or dictated by law. The previously cited authors have presented these recommendations to protect a child's rights during counseling or therapeutic interventions. A professional must make decisions and recommendations, particularly where the child's rights are concerned, depending on the variables of age and so on, as mentioned earlier.

A factor in child rights that bears ethical consideration involves children referred for therapy when the family is the presenting problem. For example, a child is referred for counseling and identified by his parents as "problematic," whereas interviews and

so on reveal a family or parental dysfunction that would warrant a family counseling or systems approach. Children may be labeled as *dysfunctional* for insurance purposes because they have no recourse or legal rights, but these reports may become detrimental to the student in the future. Additionally, a conflict in values may arise between parent and child over a treatment goal based on a parental request although the behavior causes no personal difficulties for the child. Ethically, the goal would be for the mental health provider to work with both parents and child to reach a mutual decision plan, although the needs of the student should be primary to the psychologist (NASP, 2010). These rights for children and parents are again going to be affected by the situation and clients. Professional decisions will vary from client to client as a therapist strives to protect both child's and parents' rights, while advocating for the child.

Confidentiality

Another ethical issue that regularly confronts therapists both in private practice or agency/school settings is confidentiality. All professional ethical guidelines for the various helping professions address the topic of confidentiality (ACA, 2014; APA, 2010; ASCA, 2010; NASP, 2010; NASW, 2008). The APA (2002) guidelines state that client information is confidential unless the client gives permission to reveal or discuss it. However, as Johnson et al. (1997) note, it is common for professionals to share reports on children with other professionals involved with the child, such as teachers, private psychologists, and counselors. This is done with the permission of the child's parent or legal guardian, rather than the child. It appears that the child's permission to share this information should ethically be obtained as a matter of routine. According to Glossoff and Pate (2002), elementary school counselors, are more likely to share confidential information than secondary counselors, based on information obtained in a study by Isaacs and Stone (1999). Glossoff and Pate (2002) state this fits with using a developmental framework that indicates that younger children are less able to make informed choices and are less concerned about confidentiality than older students. However, regardless of a student's age, both legal statutes and professional ethical guidelines indicate the necessity to report to the parents if a child is engaging in behaviors that are a danger to self or others or relates plans to carry out such actions and any suspected instances of abuse. The idea that danger to self or others supersedes a client's right to privacy and confidentiality is an accepted part of ethical and legal professions. However, the definition of what constitutes *danger* can be difficult to ascertain depending on the age or developmental level of a student. Findings of a 1999 study by Isaacs and Stone found that most school counselors agree that drug experimentation by an 8-year-old would require parental notification. However, there was less agreement about informing parents if a 16-year-old student reported some experimentation with marijuana. The impact of a mental health provider's personal values may also influence decision making. All instances of suspected

child abuse (physical, emotional, sexual) and neglect must be reported to a child abuse hotline or designated social services agency. It is possible for ethical and legal factors to conflict in this area, when a child may not speak to a mental health provider due to fear of parental retaliation or removal from the home. However, the law is clear that all school-based personnel are mandated to report any suspected abuse. Ethically, the mental health provider should inform the student at the beginning of a counseling session or conversation what types of information must be reported to parents or other agencies. In *Phyllis P. v. Claremont Unified School District* (1986), the California Supreme Court ruled that a school district had a mandatory duty to warn a student's parent that a child was being sexually molested, a duty to report the assaults to a child protective agency, the necessity to obtain written parent consent prior to psychological treatment, as well as a duty to ensure the student's safety and to supervise the offender.

There are also legal limitations to confidentiality such as the Family Educational Rights and Privacy Act (FERPA) and court-ordered evaluation and/or counseling, as well as release of records. In these situations, information obtained specifically must be available to parents or judicial or social services personnel. The APA (2002) guidelines (Standards 9.04 and 9.11) have eliminated the prohibition to releasing test data, such as protocols to persons who are not trained in interpretation. Without written client or parent/guardian consent, this data is released only as required by state law or court order (Smith, 2003). The 2002 guidelines also include specific definitions of test data as "raw and scaled scores, client/patient responses to test questions or stimuli, and psychologists' notes and recordings concerning client/patient statements and behavior during examination" in addition to "portions of test materials that include client/patient responses." Test materials are defined as "manuals, instruments, protocols and the test questions or stimuli" excluding test data (APA, 2002, p. 14; Section 9.11). Additional confidentiality issues, which are less specifically defined, such as those that occur during individual or group counseling, should also be considered by mental health providers. Because parents, as a child's legal guardian, in many states have access to therapy records, it seems logical to search for a level of communication that is acceptable to both parents and the child. For example, a child should be told initially in therapy what information will be shared with parents (i.e., statements of a suicidal nature or those that involve danger to others) without the child's permission. Johnson et al. (1997) recommend that therapists seek a balance between a child's and parents' rights, such as discussing general topics that arise during therapy but not the specific details.

Counseling provided in a group setting also involves protection of a child's rights of confidentiality (Jacob & Hartshorne, 2011). The APA (2002) guidelines state that psychologists who provide group counseling or therapy explain in the beginning session both the roles and responsibilities of the mental health provider and group members and the parameters of confidentiality (Smith, 2003). It is suggested that the term

confidentiality be explained to the children and adolescents at the onset of the counseling session in understandable terms (i.e., "You may talk to others about topics discussed, but not use the names of other group members"). Problems of breaking the confidentiality agreement can be decided by group members. Groups in school settings may be particularly prone to difficulties with breaking confidentiality. Although confidentiality is designed to protect the child's privacy, acceptable compromises are not always available. Therapists may find they must sometimes make decisions that alienate or upset either the child/client or parent.

An additional area related to confidentiality involves the use of the Internet electronic transmission of materials, such as reports and so on (Smith, 2003). The APA (2002) ethical guidelines state in Standard 4.02 that psychologists who offer services, products, or information through the use of faxes or e-mail must inform their clients of the risks to privacy and confidentiality.

Professional Ethical Responsibilities

In addition to ethical considerations that are primarily concerned with child and parental rights, a major issue pertaining to the service provider is professional competence or expertise in the areas of treatment to be provided. For example, a therapist trained in adult psychopathology should not ethically treat children or vice versa, without specific training. According to Johnson et al. (1997), general training in one of the mental health disciplines (i.e., clinical/counseling psychology, psychiatry, social work) does not necessarily qualify a therapist to offer psychological services to children. Some training programs may not provide either discrete didactic and clinical experiences in working with children and adolescents. Professional ethics would warrant a referral to another appropriately trained therapist under these circumstances. This area is also addressed in the ethical guidelines for all earlier mentioned mental health organizations.

A related concern involves obtaining a second professional opinion in situations where a treatment recommendation is controversial (i.e., aversive treatment) or unacceptable to parents (Koocher & Keith-Spiegel, 1990). According to APA (2002) guidelines, parents and child/adolescent clients must be informed if a treatment is considered experimental (Standard 10.01b). This should include a description of the intervention or treatment, possible risks, alternative treatments, and voluntary participation (Smith, 2003). Parents and students must also be informed if the mental health provider is an intern or practicum student at the beginning of the provision of services and if they will be discussing the case with a supervisor (Jacob & Hartshorne, 2011). Additionally, continuing education and professional growth and development are also ethically critical, particularly to ensure that a therapist is providing up-to-date treatment and therapy recommendations for a child.

RECENT ISSUES IN WORKING WITH CHILDREN AND ADOLESCENTS

There are several areas that, although they have always existed in mental health and school settings, have become more prevalent and/or frequently discussed in the professional literature as they pertain to children and adolescents. The areas are use of interpreters, interventions with culturally and linguistically diverse populations, issues of school violence (i.e., threats to a specific person, persons, or school building; possession of weapons), suicide, substance abuse, pregnancy, sexually transmitted diseases and/or birth control, and discussion of psychopharmacology with students and parents. Several of these issues also overlap with legal precedents and state or federal laws.

The APA 2002, ASCA 2010, ACA 2014, and NASP 2010 ethical guidelines emphasize the importance of knowledge and application of empirically supported interventions and assessment procedures when working with students and families from culturally and linguistically diverse backgrounds. As previously mentioned, practitioner knowledge of a student and family's culture (e.g., values, beliefs) and how they may impact learning, behavior, and acculturation is critical (Jacobsen & Hartshorne, 2011; Ortiz & Flanagan, 2002; Rhodes, Ochoa, & Ortiz, 2005). Additionally, awareness of the practitioner's cultural background, gender, class, racial or ethnic identity, sexual orientation and personal values, and prejudices and beliefs must also be personally examined to understand any impact on working with students from culturally and linguistically diverse backgrounds (Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000). The therapist needs understanding and respect for other cultural and experiential backgrounds and has the responsibility to select empirically supported interventions that are appropriate for students from diverse backgrounds and also assist parents and students to better understand the culture of the school and community (Hays, 2001). When working with students and families from diverse backgrounds, a critical factor is the practitioners awareness of personal limitations that may invalidate the evaluation or intervention (Hansen et al., 2000; NASW, 2008), such as lack of knowledge of the language, personal views, lack of necessary knowledge of the culture or previous experiences (e.g., refugees) and the impact on learning or socialization. Given the rapidly increasing cultural and linguistic diversity throughout the country and the lack of trained mental health professionals, it is critical that mental health providers engage in professional development and continuing education in this area and seek out appropriate referral resources. The use of interpreters is often necessary with children, adolescents, and parents who are not proficient in English. However, both the 2002 APA and the 2010 NASP guidelines emphasize the use of interpreters. Specifically, APA 2002 Standard 2.05 states that psychologists should attempt to avoid the use of interpreters who have a relationship with the client (e.g., sibling, relative) and ensure that the interpreter is competent. Fluency in both the

language of the student and family and English is important. Informed consent for use of an interpreter is also necessary to document the limitations of test results with respect to cultural and linguistic diversity and ensure confidentiality of the interpreter (APA, 2002; Standard 9.03).

Violence toward others by school-aged children and adolescents is a primary area of concern. Recent news reports and newspaper articles report an increase in violent crimes by progressively younger and younger children, and history has recorded the occurrences of school violence through shootings in Kentucky, Oregon, Minnesota, and most famously, Columbine, Colorado. Although schools are in theory the safest places for children (Mulvey & Cauffman, 2001), concerns about school violence and identification of students who may be at risk for violent acts and prevention programs are of prime importance. Jacob and Hartshorne (2011) state that while schools have a legal responsibility under federal, state, and case laws to protect students from harm, therapists also must take reasonable steps to prevent possible harm when their client is a threat to others (*Tarasoff v. Regents of the University of California*, 1976). Although ethically mental health providers have a mandate to report, it is difficult to determine, when students have a history of aggression, whether they are likely to commit future acts of violence and how to prevent such acts. Borum (2000) advocates that practitioners use a student's history of violent acts, the antecedents to the acts, and protective factors (e.g., What would help a student avoid a situation that can trigger aggressive actions?) in working preventatively with a student. However, when a student is referred to a mental health provider due to targeted violence, both the perpetrator and potential victim must be identified prior to the violent incident (Jacob & Hartshorne, 2011). Consultation with other mental health professionals is recommended (Waldo & Malley, 1992) when making the determination of a risk for violence. Parental notification that their child is a potential target is important for students, particularly for minor children, but in addition the therapist needs to inform the parents of the possible perpetrator. Knowledge of community referral sources for the family is important. Legal precedents related to school violence will be presented later in the chapter.

Suicide, according to the Centers for Disease Control (2012), is in the top three causes of death for adolescents. As previously mentioned, mental health practitioners in private practice, community, and school settings are ethically bound to report suicidal ideations or attempts to parents. Poland (1989) noted that although parent notification is necessary, informing the parents in a manner that is supportive and that will elicit their positive reactions or responses is critical. A parental signature documenting that they were informed about their child's suicidal threats or attempts is recommended, along with suggestions for home (e.g., supervision needs, removal of access to weapons) and community referral sources for further evaluation and therapy. Ethically, simply informing a parent about a student's suicidal threats is not sufficient. Steps to ensure the safety of

the student such as those just mentioned are necessary. Poland (1989) recommends that social services be contacted for possible neglect charges if the parents refuse to follow through on treatment recommendations.

With the well-documented increase in the use of medications with children and adolescents through research articles and the media, another ethical area for mental health providers, particularly those in school settings, is related to discussing possible medication use with parents and informing parents when their child is not taking medication. The latter is a particularly difficult ethical area for practitioners because the behavior may not be immediately dangerous and decision making about parent informing should be based on factors related to the student's age, ability to make informed judgments, and harm to self as a result of discontinuation of the medication. Discussions with the student about concerns related to the risk-taking behavior and knowledge of state and school regulations are important.

Areas related to sexuality (e.g., birth control, sexually transmitted diseases, abortion), although legally dictated in some states and through school policies in others, present ethical dilemmas for a mental health provider, particularly those who are school-based. These areas are controversial and personally value-based. It is important that practitioners who work with adolescents be knowledgeable about school policies as well as state statutes with respect to referrals, provision of information, parental notification, and so on. Ethically, the mental health provider may be placed in the situation where information that is requested (e.g., referral for an abortion) is against school policy. Knowledge of community resources that present a fair presentation of alternatives for students is important. Additionally, it is important that professionals be aware of their personal values and separate them from those of the client. Knowledge of and referral to appropriate community physicians and family planning or health clinics is necessary for mental health practitioners working with adolescents.

LEGAL ISSUES

As previously mentioned, there is often overlap between legal and ethical aspects related to the provision of mental health services to children and adolescents. Generally, when legal statutes exist, mental health practitioners follow them, as indicated by professional organization codes of conduct and ethics. In our increasingly litigious society, a wider range of cases are decided by the courts, including those related to school policies and procedures, mental health services, instruction, and medication use. Although there are legal statutes and decisions that have clarified some aspects of provision of service to children, specifically related to parental notification or rights and unbiased assessment, others are recent decisions, such as those related to school violence. It is imperative that

mental health providers continue to review state and federal statutes as well as court decisions as they impact services to children and adolescents.

Relevant Case Law

Three rather broad and interrelated domains of law are discussed in this section as they apply to interventions: (1) confidentiality and privileged communication, (2) informed consent, and (3) access to records.

Confidentiality and Privileged Communication

Although frequently used interchangeably, important distinctions exist between the legal concepts of *confidentiality* and *privileged communication*. Confidentiality refers to a general obligation of a professional to avoid disclosing information regarding the relationship with a client to any third party (Bersoff, 2003) and includes "more broadly the legal rules and ethical standards that protect an individual from unauthorized disclosure of information" (p. 159). Privileged communication is narrower in scope than confidentiality. As Jagim, Wittman, and Noll (1978) note, "Whereas confidentiality concerns matters of communication outside the courtroom, privilege protects clients from disclosure in judicial proceedings" (p. 459). Thus, although an obligation to preserve confidentiality constitutes a broad duty owed by a professional to a client, "Psychotherapist-patient privilege is a rule of evidence relevant only in court proceedings" (Hulteng & Goldman, 1987, p. 239).

The doctrine of privileged communication has partially, but not completely, protected a client's right to privacy in that confidential information can be withheld in a court if it is identified as privileged communication (Bersoff, 2003). Bersoff further states that in order for information to be considered confidential, four requirements must be met:

1. Communications must be to a licensed or certified therapist as described in the state's statute.
2. A professional relationship must exist between the client and therapist.
3. Information must be related to the provision of professional services.
4. Communications must be confidential and not released to a third party.

The notion of a *special relationship* forms the basis of privilege as it applies to disclosures in the courtroom. The laws of various states ultimately govern the scope of privileged communication but may include husband-wife, attorney-client, member of clergy-penitent, and physician-patient relationships (Fischer & Sorenson, 1996). Most psychologists have privileged communications from disclosure of psychologist-client communications that are privileged from disclosure in court in 41 states. All 50 states

have regulations that apply for school counselors (Herlihy & Sheeley, 1986) although the specifics and nature of the privileged communication statutes vary from state to state. Professionals need to be aware of the specific privileges, limits, and exceptions associated with their licenses and certifications in their state statutes. For example, some states limit privileged communication to drug and alcohol issues. In some cases, the statutes change for students at different ages. And some professionals may hold dual credentials (e.g., certified as a school psychologist through the state department of education as well as being a licensed psychologist for independent practice by the state psychology board). The professional's rights may vary depending on certification and licensure, as well as the setting of their work with clients. Bersoff (2003) states that the concepts of privilege and confidentiality have become "increasingly subject to exceptions and limitations, … by inconsistent federal and state rules and threatened by changes in health-care financing" (p. 160). Even in states that have statutes regarding privilege, this right is typically granted to clients of psychologists—not psychologists themselves. Because the right to assert or waive the privilege to prevent disclosure in courtroom proceedings is granted to the client, issues of competency are often involved. Typically, the child mental health practitioner's client is a minor and is, therefore, considered legally incompetent to exercise the privilege. Although children ethically have the same rights to confidentiality as adults, legally this is not true. Parents, with minimal exceptions, have the legal right to control mental health services for their child and to be involved in the planning (Birdsall & Hubert, 2000). Waiving of psychologist-client confidentiality can also reduce the scope of privilege (Bersoff, 2003).

In states protecting the relationship between clients and psychologists, the term *psychologist* usually refers to those who have been licensed, registered, or certified by a state board of examiners or similar body for the purpose of regulating the public and private practice of psychology. This, for example, frequently excludes "school psychologists" or others using similar titles, but who are not licensed. Jacob and Hartshorne (2003) note that it is important that school psychologists recognize that the courts view their professional credentials differently than a licensed psychologist who works in a non-school setting.

School-based professionals should note that once information is included in a school file, it cannot be considered potentially privileged communication but, in fact, falls under the provisions of FERPA, which governs access and privacy. Privileged communication statutes, even when they do exist, do not represent absolute guarantees. Even when there is statutory support, extenuating circumstances could include client request, and clear and imminent danger to the client or others (Herlihy & Sheeley, 1986). Information contained in a student's due process file, under the Individuals with Disabilities Improvement Education Act (IDEIA; 2004), while released only with written parent

consent, is also not generally considered privileged information because it is accessible to school personnel.

As Fischer and Sorenson (1996) note, case law in this area has a relatively long history, but even in long-recognized exemptions, such as attorney-client relationships, courts have demanded that certain conditions be met. The courts have generally held that mental health professionals have a common-law obligation to protect the confidentiality of the relationship with a client (Hulteng & Goldman, 1987). Across a number of decisions, it appears that the following are three minimal conditions to establish for privilege and confidentiality:

1. One party in the relationship must be legally certified as a lawyer, doctor, psychologist, counselor, social worker, or minister.
2. At the time of the communication in question, he or she must have been acting in a professional capacity.
3. The person making the communication, if in possession of his or her faculties, must have regarded the professional person as his or her lawyer, doctor, psychologist, counselor, social worker, or minister.

Another exception to client confidentiality is related to the "duty to warn principle" that presents the confidential relationship of a professional and client when threats toward others have been made. This was decided in the landmark and well-known case in 1976, *Tarasoff v. Regents of the University of California*. The *Tarasoff* case revolved around a suit filed by the parents of Tatiana Tarasoff, who was killed in 1969 by the patient of a University of California hospital psychologist. Two months prior to her death, during therapy sessions with the psychologist, the patient had confided his intention to kill Ms. Tarasoff. The Tarasoffs' suit claimed that there was a "duty to warn" their daughter of the impending danger. Although the psychologist notified the campus police, the California Supreme Court ruled that the psychologist did indeed have a duty to warn a known, intended victim directly. The court held that a special relationship existed between any therapist and patient and that the duty arising from the therapist's knowledge that his patient posed a serious threat of violence meant reasonable care must be taken to protect a foreseeable victim of potential violence (George, 1985). To breach a potentially dangerous client's confidentiality, three requirements must be met:

1. The information must be communicated directly to the therapist.
2. Serious threat of physical harm is imminent based on an evaluation for serious threat to harm.
3. The potential victim can be reasonably identified by the mental health professional.

The California Supreme Court also stated that the following be completed when these three requirements are met:

1. Notify the potential victims.
2. Notify the authorities.
3. Take steps to prevent the threatened danger (Harmell, 2005).

Individual states have laws relating to *Tarasoff* with which mental health providers should become familiar. In 1994, another case related to *Tarasoff* was also tried in the California Appellate court (*Gross v. Allen*, 22 Cal. App. 4th 354). This case involved a university student who was adamant about admission to an inpatient eating disorders clinic after gaining weight due to prolixin injections. She was given the medication through injection rather than orally since she was seriously suicidal and had previously overdosed on medications, in addition to other suicide attempts through various means. Her psychiatrist "forbade" her to enter the program, stating that it was inappropriate given her current suicidal ideations and previous attempts. She attempted to gain admission to the program through a meeting with the program director. He then contacted her psychiatrist at the university, who did not inform the program director of her severe suicidal behavior, although he stated that he had extreme objections to the appropriateness of the program. The patient was admitted and overdosed on prolixin tabs that she had been hiding and was left with permanent brain damage after 5 weeks in a coma. The mother sued the hospital, which cross-sued the university, and she won settlements from both. The appellate court ruled that there is a duty to inform serious threats or known dangers to a patient's caregivers when the patient is a danger to herself. According to C. Meyer (1997), this ruling is a duty to inform rather than a duty to warn. Ethically, mental health professionals must be careful when sharing information about a suicidal patient without consent (Harmell, 2005). Another court ruling related to *Tarasoff*, *Bellah v. Greenson* (1978), was heard by a California appellate court and involved a young adult patient who was suicidal and had a significant substance abuse problem and the psychiatrist did not inform her parents. She overdosed and her parents sued with the intent of extending *Tarasoff* to include duty to warn of suicide. Although, according to Harmell (2005), it appeared that the three requirements of Tarasoff were met, the court did not extend the previous ruling to include suicide and there have been no subsequent court rulings that extended *Tarasoff* to include suicide. C. Meyer (1997) reported that in a reanalysis of *Bellah* it appears that the reason that is was not extended to include suicide is that the statute of limitations had expired in which to file the case. In 2004, another addition to the *Tarasoff* case was tried in a California appellate court, *Ewing v. Goldstein*. The case involved a marriage and family therapist who was treating a client for 4 years for work-related problems and a relationship breakup. After learning

of his previous girlfriend's involvement with another man, he became more depressed and reported suicidal ideations, although he was not actively suicidal. Hospitalization was discussed and permission was obtained to speak to the client's father. The client subsequently reported severe depression to his parents related to his girlfriend's new relationship and was resentful toward the man and was considering doing harm to him. Hospitalization was arranged after communication between the client's father and therapist. He was admitted one evening and discharged the next morning with no contact between the admitting psychiatrist and the therapist, until the therapist contacted the physician and urged him to keep the patient hospitalized. However, the hospital discharged the client that morning and he killed the new boyfriend and then committed suicide the next day. The boyfriend's parents sued the therapist for wrongful death based on professional negligence (i.e., failure to warn their son or a law enforcement of imminent danger). The therapist argued that he was not directly informed of the threat by the client, but by his father and that he had not been told the boyfriend's surname. The court ruled against the parents, but on appeal it was decided "that communication from a family member to the patient's therapist for the purpose of advancing the patient's therapy, is a patient communication" (Harmell, 2005, p. 18). A mental health provider's duty to warn a victim occurs if the information provided to the therapist leads to a belief that the client is a serious risk of bodily injury to another. Although the *Tarasoff* case and other related cases did not involve school-based mental health professionals, the implications for duty to warn and inform seem applicable, particularly when minor children are involved, particularly with respect to school-based violence. Student threats to injure others need to be taken seriously based on *Miranda v. Board of Education of the City of New York* (1994). Another legal decision in 2000, *Milligan et al. v. City of Slidell*, ruled that school personnel and police can legally detain and question a student thought to be planning a violent act at the school. The school's interest in preventing violence was reported to outweigh the student's Fourth Amendment rights to privacy (Jacob & Hartshorne, 2011). Given the *Ewing v. Goldstein* decision, it is unclear how far the chain of communication will obligate professionals to take *Tarasoff*-like actions. For example, if a teacher communicates a child's threats to a psychologist, does this obligate the psychologist to take appropriate action?

Legal decisions related to suicidal ideations reported to school personnel were made in *Kelson v. City of Springfield* (1985) and *Eisel v. Board of Education* (1991). Decisions in both cases, in addition to others, suggest that schools should develop clear suicide prevention policies and procedures that include parental notification and appropriate staff training (Jacob & Hartshorne, 2003). Failure to communicate with parents (i.e., *Eisel* case) about possible suicidal ideation and appropriateness of school policies (e.g., lack of suicide prevention training) and the death of a student (i.e., *Kelson*), indicate the court's view of the school's role in the duty to warn or inform.

The importance and legal mandates to report suspected child abuse has been documented in the California court case, *Phyllis P. v. Claremont Unified School District* (1986), where the state supreme court held that a principal, teacher, and school psychologist failed to comply with their duty to warn the mother of an 8-year-old girl that her daughter was being sexually molested by another student at the school. The student, Phyllis P., stated to her teacher that another student was "playing games" with her. The teacher told the school psychologist, and the school psychologist initiated counseling. The principal was also aware of the situation. The court noted that the school not only failed to notify the mother that the assaults were taking place but also neglected to obtain informed consent for treatment and did not properly supervise the molesting student. Additionally, the court held that the mother could sue the district for this failure to warn. In another case (*Pesce v. J. Sterling Morton High School District 201,* 1987), the courts ruled that a school psychologist could be disciplined for misconduct for failure to report child abuse in a timely manner.

Confidentiality and privileged communication are two distinct concepts and should not be used interchangeably. Though emerging case law supports a common-law obligation to preserve confidentiality, it is largely an ethical consideration. Privilege, alternatively, deals with the admissibility of evidence into court. Although various states have enacted statutes that grant these exceptions beyond the historical relationships (e.g., lawyer-client, minister-penitent) to psychologist-client, some professionals may nonetheless have a legal duty to testify if ordered by a court (Fischer & Sorenson, 1996). Refusal to do so may lead to contempt citations, fines, or jail terms. Moreover, the privilege belongs to the client and not the therapist.

The *Tarasoff* case and other similar cases (e.g., *Hedlund v. Superior Court,* 1983) have caused considerable furor among mental health professionals. In tempering the paranoia generated by these cases, George (1985) states, "the determinative question remains whether the professional person failed to exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances" (p. 294). Although the controversy remains, several state legislatures have enacted laws that limit the potential liability to some degree. It is perhaps safest to assume that professionals have a duty to warn known intended victims of their client's violent intent (Fischer & Sorenson, 1996).

In circumstances where a client expresses violent or harmful intentions toward another individual, a therapist has the duty to warn potential victims who are the targets of such threats. Further, professionals may not only have the duty to warn but also infer the duty to protect third parties from violent acts (Mills, 1985). It is also clear that most professionals are "mandated reporters" for suspected cases of child abuse discovered in the course of their practice. Failure to report as required by state statute can result in both civil and criminal liability (Hulteng & Goldman, 1987).

All 50 states have passed legislation that requires school personnel to report suspected cases of child abuse (Jacob & Hartshorne, 2011). It is important to note that the law does not state that the school personnel reports abuse not only when documented but also when suspected, and the child protective agency determines whether abuse has occurred (*State v. Grover,* 1989). Immunity from prosecution in civil and criminal cases is provided when reports are made in "good faith."

The information contained in case law decisions indicates that the duty to report/warn/inform is a critical aspect of provision of mental health services to children (whether it involves reporting suspected cases of child abuse in a timely manner to child protective services or informing parents of acts of abuse or aggression that have been made toward their child as well as suicidal or violent ideations toward self or others), including the duty to warn a potential victim and law enforcement authorities. The premise of "do no harm" relates not only to the client, but also to others who may be impacted by the client's behavior.

Informed Consent

The term *informed consent* refers to the "receipt of specific permission to do something following a complete explanation of the nature, purpose and potential risks involved" (DeMers, 1986, p. 45). Informed consent is defined legally as involving three aspects: (1) knowledge, (2) competence or intelligence, and (3) voluntariness (Arambula, DeKraai, & Sales, 1993; DeMers, 1986; Grisso & Vierling, 1978). Under the strictest of interpretations, the knowledge test requires that a professional fully inform the student/client/parent of all relevant information about a specific intervention approach so that the person becomes "aware" of what is being consented to. The intelligence or competence aspect of consent focuses on the ability of the child or parent to arrive at the consent rationally and independently. The idea that a student's ability to make an informed decision changes from one day at age 17 to another when he is 18 years of age is not logical. In this concept are the notions of cognitive capacity and other mental health-related abilities of a child or adolescent. Informed consent, according to Jacob and Hartshorne (2011), includes issues such as consent for experimental treatments, student self-referrals, and supervision and consultation consent. As previously mentioned, it is the mental health provider's responsibility to clearly inform the client (child or adolescent) and parents about not only the treatment plan and its effectiveness but also the experimental nature of any intervention. Ultimately, parents are the legal decision makers for their minor child. Parents and the child (when school age in most cases) should also be told when a professional's expertise in an area is newly acquired (Jacob & Hartshorne, 2011).

Informed consent as it pertains to a student's self-referral for counseling involves a child or adolescent's ability to decide for him- or herself that counseling is needed.

This may involve a student requesting to speak with the school psychologist and happens more often at the secondary than elementary level. Ethical guidelines for both APA (2002) and NASP (2010) indicate that written parent consent is needed for provision of services to minors, which is based on state laws that identify parents as the guardians or decision makers for the services their child receives. Instances where the state is the guardian of a child or an adolescent is emancipated are exceptions. Access for treatment for minors is allowed in some states but generally involves medical treatment, such as substance abuse, and most often does extend to the school setting (Jacob & Hartshorne, 2011). Although parent consent is needed for ongoing treatment or counseling, a pre-counseling meeting (Canter, 1989) to assess for safety factors is suggested with the need for parent consent explained to the student.

Practicum and intern experiences are an integral part of graduate training programs in school psychology, clinical psychology, social work, and school counseling. However, although this training is important for the skill development of the graduate student, parents and adult students need to be informed that treatment will be completed by a student. This information should be provided prior to the commencement of services. It is also important that the role of supervisors or consultants be explained specifically with respect to information that will be shared and their role in treatment planning. Knapp and VandeCreek (1997) recommend that parents and adult students be given contact numbers for the student's supervisor.

Bray, Shepherd, and Hays (1985) suggest that the following must be included for valid consent: (a) a complete explanation of the treatment, risks, discomforts, and benefits; (b) a description of other possible treatment alternatives; (c) an offer to discuss the procedures or answer any questions; and (d) the information that the client is free to withdraw consent at any time and discontinue treatment. Consent obtained pursuant to these disclosures will be *express consent*. *Apparent consent* and *consent implied by law* are two other types of consent. In apparent consent, all parties act as if consent was given, when in actuality none was formally stated. Consent implied by law comes into play in questions of competency for clients most frequently seen by mental health professionals in hospital or inpatient settings (Slovenko, 1973).

One of the major controversies in this area is the age at which a person may legally consent to treatment (Bray et al., 1985; Grisso & Vierling, 1978; Jacob & Hartshorne, 2011; Sadoff, 1985). Although Bersoff (1982) notes that there has been a general trend for the courts to grant adolescents greater leeway in obtaining medical or psychological intervention without parental permission, there is no question that treatment of preadolescents should involve the consent of parents or legal guardians (Reynolds, Gutkin, Elliot, & Witt, 1984).

An issue tangentially related to informed consent involves discussing medication trials for a student with his or her parents or guardian. With the increase in the

prescription of medications to children and adolescents, many of which have been tested only on adults, it is important that school-based mental health professionals be aware of characteristics of commonly prescribed medications, such as side effects and length of time for therapeutic effects to be noted, and impact of sudden discontinuation of medications. Generally, legal decisions have supported the parents' right to make decisions about medications that are prescribed to their children, and this is viewed as an issue to be decided between parent and physician. Litigation that involved a school district's request for a child taking a prescription medication to be allowed to attend school have not been upheld. In *Benskin v. Taft City School District* (1980), a California court approved a settlement lawsuit brought by 18 students and their parents that claimed that the school district and staff pressured them to place their children on medications without complete evaluations and minimal or no classroom interventions. The court decision gave policy clarifications that prevented a school district from diagnosing ADHD or recommending that a child take medications for this disorder. In *Valerie v. Derry CO-OP School District* (1991), the court upheld that schools may not require that a child take Ritalin as a condition for school attendance. According to Jacob and Hartshorne (2011), Connecticut, in 2001, became the first state to prohibit school personnel from suggesting psychiatric medications to a parent. Because school district and state policies vary, it is important for school-based mental health providers to be knowledgeable about the policies in their area of residence.

Access to Records and Right to Privacy

An analogous concern to the confidentiality and privilege issue is the privacy right granted by FERPA (1974; popularly known as the Buckley Amendment). Although privilege was previously referred to as the protection of testimony or professional opinion about a client, the *data privacy* notion discussed in this section is more concerned with the release and storage of information (Lombard, 1981).

The Family Educational Rights and Privacy Act essentially mandates the withholding of federal funds to schools or other educational agencies that fail to require parental consent or a court order for the release of records for other than defined educational purposes. With the increasing use of courts to resolve custody, child abuse/neglect, juvenile delinquency, and status offenses, the records of school-based professionals are often subpoenaed by clients, states, and adversarial parties. A subpoena may require the production of records, including notes, tape recordings, videotapes, memoranda, letters, and any other written material (Schrier, 1980). Though a detailed listing of all the provisions contained in FERPA is beyond the scope of this chapter, important requirements include that (a) parents or students age 18 years or older be told the reasons for release and be given a copy of any released records, (b) parents be notified of any court order in advance of any release to have an opportunity to contest the contents of school records,

and (c) parents can insert modifications into the record and challenge the contents. Parental consent must be obtained for release of information for children under age 18. For students 18 years of age or over, or those attending postsecondary education, the rights for permission or consent shift from the parents to the student.

The Family Educational Rights and Privacy Act does contain an exclusory clause regarding the personal records of psychologists and counselors if these files are entirely private and not available to other individuals. This "memory aids" exception makes clear that private files of this type shall not be shared with or passed on to any other school personnel. They can be shared with a "substitute" without thereby becoming "education records" subject to FERPA (Fischer & Sorenson, 1996).

The Family Educational Rights and Privacy Act also requires that a record be kept of all parties requesting and receiving student information and that this record be made available to parents or eligible students. School districts may, however, develop policies to allow for undocumented exchanges between local district personnel by explicitly stating which school officials may have access without parental permission and noting the "legitimate educational interests" justifying the access.

With respect to the release of school records to noncustodial parents, both FERPA and *Page v. Rotterdam-Mohonasen Central School District* (1982) clearly entitle the noncustodial parent to the same access of the child's educational records as the custodial parent (Fischer & Sorenson, 1996). This assumes that no specific court order prohibits contact between the child and the noncustodial parent. The federal law indicates that school professionals may assume a noncustodial parent's right to information unless otherwise stipulated. In cases where a child has no parent or legal guardian, educational records must also be accessible to a guardian or "an individual acting as a parent" (Fischer & Sorenson, 1996). Additionally, noncustodial parents are entitled to any school communications that are sent to the custodial parent.

In a case involving children abused by a school employee, the courts ruled in *Parents Against Abuse in Schools v. Williamsport Area School District* (1991) that interview notes of a school psychologist should be released to parents. After allegations and evidence of abuse became known, the school psychologist had interviewed the students to assess the nature of the abuse and potential emotional consequences, and to assist the parents in arranging for appropriate therapy for their children, if needed. The issue involved whether FERPA provisions covered these notes. The court ruled that FERPA provisions did apply and ordered the release of the interview notes. Thus, even more informal "clinical" notes do not avoid release to parents if requested.

The Health Insurance Portability and Accountability Act (1996) dictates that therapists follow federal guidelines related to patient confidentiality in the areas of informed consent, record storage, employee training, record security, and some electronic transmissions of patient information (Harmell, 2005). Under HIPPA, electronic transmission

includes the use of computers to send information through attachments or e-mail and computer faxes, but does not include freestanding fax machines or telephone lines. Parents of minor children and adult students must be informed of possible problems with confidentiality through electronic transmissions. Under HIPPA, private notes of a psychologist are not available to the client or insurance company, although progress notes are. Therapy notes must be kept in separate files and are able to be subpoenaed by court order.

SCHOOL-BASED INTERVENTIONS

The NASP (2010) principles for professional ethics states that "School psychologists actively monitor the impact of their recommendations and intervention plans. They revise a recommendation, or modify or terminate an intervention plan, when data indicate the desired outcomes are not being attained. School psychologists seek the assistance of others in supervisory, consultative, or referral roles when progress monitoring indicates that their recommendations and interventions are not effective in assisting a client." (p. 7; Principle II.2., Standard II. 2.2). This premise is also supported by American Psychological Association's (2002) ethical standards and American School Counselor Association (2010) standards. A primary intervention used in schools by mental health providers is related to plans to change behavior, increase desired, appropriate behaviors, and reduce the occurrence and frequency of disruptive, inappropriate behaviors. The IDEIA reauthorization in 2004 now requires that evidence-based behavioral interventions be used for children with disabilities when behaviors are disruptive to learning and also as part of prereferral interventions for children with possible learning disabilities (Brown-Chidsey & Steege, 2005). The emphasis is on planned, empirically based interventions that monitor a student's progress in academic and behavioral areas when a specific intervention is implemented.

Behavioral Interventions

According to Jacob and Hartshorne (2011), behavioral interventions refer to planned and systematic use of learning principles to change a child's behavior through directly working with the child or through teacher and parent consultation and collaboration. Generally, the teacher is viewed as the primary change agent, although the parent should be included in all interventions. Legal issues associated with behavioral interventions include problem identification, intervention, and monitoring.

During problem identification, the behavior of concern is specifically and operationally defined, the situations under which this occurs and the antecedents and consequences to the behavior are specified, as well as behavioral frequency. Information obtained at this time leads to intervention goals. Potential problems related to problem

identification involve selection of objectives that are appropriate for the child. According to Winnett and Winkler (1972), behavior modification techniques in the late-1960s had an emphasis on teaching children to "be still, be quiet, and be docile." Behaviors to be changed often focused on teacher needs rather than on facilitating a child's learning. Harris and Kapche (1978) state that the psychologist is ethically required to teach replacement behaviors that will facilitate future learning. Realistic goal setting is a critical aspect of problem identification. Yell, Drasgow, and Ford (2000), cited in Jacob and Hartshorne (2011), identify a functional behavioral assessment (FBA), as required by IDEA, as a mechanism to determine the function that a problem behavior serves for a child and involves naturalistic (classroom) and direct observations, teacher and parent information, and an analysis component in which factors that are identified as impacting the behavior are changed. For example, a disruptive student is seated next to a quiet student who is unlikely to respond to comments.

The Individuals with Disabilities Improvement Education Act requires that a behavior intervention plan be developed after completion of the FBA. School psychologists are ethically expected to recommend interventions that are effective, act in the least drastic way, and minimize adverse effects (Jacob & Hartshorne, 2011). In general, the more invasive and restrictive the intervention, the less defensible the intervention is from a legal and ethical standpoint. Additionally, aversive techniques are of questionable utility, as well as leading to potential legal issues (see Jacob-Timm, 1996; Repp & Singh, 1990, provide reviews of aversive techniques and issues associated with the use of aversive techniques).

GROUP TREATMENTS

R. Meyer and Smith (1977) present four interrelated axioms regarding the efficacy of group therapy. The first two are useful to the discussion of legal issues. R. Meyer and Smith (1977) submit that (1) confidences divulged in group therapy have the same protection under statutes of privileged communication as do those revelations made in individual therapy; and (2) confidentiality is crucial to the effectiveness of group therapy (p. 638). Despite the inherent soundness of these statements, the courts have not agreed that the status of privileged communication applies to group treatments. As Fischer and Sorenson (1996) submit, this is rooted in the reluctance of courts to grant privilege or extend it to new types of relationships. Only the state of Colorado has statutes that recognize privilege for participants in group therapy. Thus, although the vast majority of group therapists and clients assume that the axiom of privilege is in effect (R. Meyer & Smith, 1977), there is little or no statutory or judicial assurance for this assumption.

CONCLUSION

Conducting psychological treatments for social-emotional problems of children and adolescents is a complex and challenging task. The clinical concerns and questions are compounded by an array of ethical and legal issues. Clinical options and plans must necessarily take these issues into consideration. At a basic level, the ethical principles of the major helping professions provide an overall guide for professional behavior. Because of their age, developmental level, and the concerns of others (e.g., parents, schools), child clients present unique ethical considerations. Similarly, there are some general legal issues that apply to persons receiving mental health services, and these are made more complicated by the status of child and adolescent clients as minors. Both statutes and relevant case law provide further guides for professional behavior. The premises of child advocacy and use of empirically based treatment strategies are both ethically and legally mandated through organizational codes of ethics and statutes such as IDEA.

Although some questions in the ethical and legal areas have relatively straightforward answers, many gray areas remain. Ethical principles and legal statutes and case law do not completely overlap. In some cases, ethical principles may come into conflict with legal guidelines. This chapter has highlighted some of the major issues when working with children and adolescents. Finally, we concur with the conclusion of Huey (1986)—ethical codes do not supersede the law, but legal knowledge may not always be sufficient to determine the most appropriate course of action.

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CHAPTER

3

Culturally Responsive Interpersonal Psychotherapy with Children and Adolescents

JANINE JONES

The future is near and our population is changing. For the first time in history, America's racial and ethnic minorities represent 49.9% of children under the age of 5 (U.S. Census Bureau, 2012). This demographic shift in our population is significant because the census bureau predicts that by 2017, racial and ethnic minorities will make up more than half of children under 18 (2012). This demographic shift is particularly present in 11% of counties in the United States, which are now considered "majority-minority." Additionally, in 2012, 13 states and the District of Columbia had a population of children 0 to 5 years old that was "majority-minority." Thus, the professionals that serve school age children must be prepared to work with children and families from diverse backgrounds.

To provide culturally responsive intervention services, a considerable effort must go into the design and process of treatment. This chapter begins with addressing the ethical standards for practice and basic constructs in multiculturalism. Aligned with the competency-based approach to multicultural therapy, the chapter is organized around the therapeutic relationship, the therapeutic process, and the application of skills through a case study. The primary focus of the treatment process is linked to a culturally adapted version of an evidence-based approach to therapy—interpersonal psychotherapy. Thus, this chapter can be used as a guide for a therapist to provide culturally responsive treatment for children and adolescents in schools and clinic settings.

MULTICULTURAL STANDARDS OF PRACTICE

As our society has become increasingly multicultural, our national organizations have developed guidelines on multicultural education, training, research, and practice. Since the early 1990s, psychological organizations began acknowledging the importance of culturally centered practice through the development of practice guidelines and suggested competencies. For example, the American Psychological Association has adopted six guidelines for psychologists to consider when providing psychological services. The APA guidelines address the contexts of clinical practice, training, research, and organizational development (American Psychological Association, 2003). The six guidelines are shown in Table 3.1. Prior to the adoption of the APA guidelines, the Association for Multicultural Counseling and Development developed a set of 34 multicultural counseling competencies (Sue, Arredondo, & McDavis, 1992). The goals of the competencies are to address three domains of competence: cultural self-awareness, knowledge of the worldview of the client, and developing culturally appropriate skills or intervention strategies. Subsequently, both the American Counseling Association and the American Psychological Association endorsed these competencies.

Basic Considerations

In order for clinicians to adopt a culturally responsive frame of reference, there must be a clear understanding of the basic constructs and language used around multiculturalism.

Table 3.1 APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists

Guideline	Description
1	Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.
2	Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.
3	As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.
4	Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.
5	Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices.
6	Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices.

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Source: American Psychological Association (2003).

Clinicians must recognize and use the concepts in the context of treatment, as the concepts are not only meaningful to professionals but also to clients. These concepts are the foundational principles of culturally responsive treatment and are included in the multicultural standards of practice.

Culture

According to Banks and McGee Banks (2004), culture includes shared ideas, symbols, values, and beliefs between members of a group. Culture encompasses any of the following categories: race, socioeconomic status, language, ethnicity, disability, sexual orientation, and religious/spiritual identity. Culture impacts everything we think, do, and feel in a given day; therefore, it is the lens through which we view the world. Cultural worldview is a term to describe expressions of commonality among a group of individuals that share a common concept of reality (Jenkins, 2006).

Multicultural

Many different terms are used to describe the intersecting variables of culture, ethnicity, race, identity, and difference. By using the term multicultural, it is recognized that people are inevitably part of multiple cultures. They have the ability to understand and function in multiple cultural environments—while being able to adjust their behavior to the norms of each culture.

The term *multicultural* applies to "a confluence of three or more coexisting and unintegrated cultures (e.g., those that differ by age, gender, race, ethnicity, social class, or sexual orientation), each of which displays patterns of human behavior" (Oakland, 2005, p. 6). Our behavior is guided by thinking and feeling and the intergenerational transmission of our cultural worldview sustains patterns of behavior. Sue and Sue (2013) affirmed that in multiculturalism, behavior can only be understood within the context that the behaviors exist. By using the prefix *multi-*, in the word multicultural, we honor the human variation that exists between and within groups. We recognize that the intersection of our cultural identities may vary dependent on the context. This is an important construct to understand because there is always potential for incongruence between the multidimensional cultures of the client and the therapist and in the therapeutic relationship. Thus, careful attention must be paid to the interaction of the therapist-client cultures in the therapeutic process. If the therapist adopts a multicultural frame of reference, they will apply a multicultural lens to conceptualize the clinical work, the counseling relationship, and to determine culturally relevant treatment outcomes. This clinical approach leads to multicultural competence.

Multicultural Competence

According to Lynch and Hanson (2004), cultural competence is a process and includes the ability to "think, feel, and act in ways that acknowledge, respect, and build on ethnic,

socio-cultural, and linguistic diversity" (p. 43). To practice in multicultural competence, one would demonstrate respect and skills in integrating multiple aspects of diversity simultaneously.

Collectivistic Orientation

Collectivism is a worldview that emphasizes the interdependence of every human—a view that people need to connect with one another for survival. Collectivism is a basic cultural element that stresses the importance of cohesion within social groups and in many cases; the group goals are prioritized over individual goals. Many communities of color (ethnic minority groups) operate in this manner. There is a core focus on remaining connected in the community and working on behalf of the goals of the community, and the sense of "we" is much more important than self-determination. In collectivism, success for the group is seen as a greater achievement than success of an individual. With children and adolescents, the family is the primary "group" and like-minded peers are the "social group" where the cultural norms are often enacted. In communities of color, the emphases on family and group orientation are common cultural norms. People within the group are expected to strive toward family goals and not engage in behaviors that could bring dishonor to the family and/or reputation of the family. Similarly, adolescents may seek relationships with people that have similar appearance, values, and backgrounds. Therapists must consider patterns of collectivism as a cultural norm that may be linked to behavior in a positive way (adaptability and social support) or negative way (cultural conflict, isolation, social stress).

The Therapeutic Relationship

The therapeutic relationship includes not just the therapist and the child or adolescent—it also includes the family and culture in which the child is embedded (Jones, 2008). Thus, treatment must focus on the interaction of the variables *between* the therapist and the client. The therapist should have good self-awareness of cultural values and beliefs while also building an understanding of other cultures.

When the therapist is learning more about other cultures, they must be attuned to the fact that they are incorporating new information through a filter—their own lens in which they interpret meaning of the world. Awareness of that filter is key to developing cultural literacy that is free of bias. In the Sue and Sue (2013) model of multicultural counseling, there is a tripartite approach to developing competence of the therapist: building self-awareness, developing cultural literacy, and applying clinical skills through a multicultural frame. This is a well-established standard for developing basic skills in multicultural counseling competence.

Self-Awareness

One of the first steps to becoming a culturally responsive therapist is to build cultural self-awareness. Becoming self aware is much like the skills involved in mindfulness—the therapist must be sensitive to the assumptions, values, and biases that are inherent to all people and recognize how these characteristics impact their relationships with others. In clinical training programs, faculty usually prepares students by having them look at assumptions related to race, ethnicity, socioeconomic status, sexual orientation, and family status. However, once students graduate and become professionals, it is their responsibility to continue to build self-awareness. Unfortunately, many therapists stop the self-awareness process and only focus on the interventions that they may apply universally to all clients. At a minimum, therapists should use culturally responsive treatment approaches that will require the analysis and integration of cultural values in the treatment. This will, in turn, increase the likelihood that self-awareness will continue to grow.

Building Cultural Literacy

Learning about the norms and mores of a given culture is one technique that is essential to understanding the worldview of culturally diverse clients. Building cultural literacy (or cultural understanding) is also a continual process that will grow with every interaction with a cross-cultural therapeutic relationship. The process of growth is optimal when both cultural self-awareness and cultural literacy are developing simultaneously. For example, therapists may wonder why clients choose a coping skill that differs from their own approach to coping. The only solution is to inquire about the cultural context and the meaning of the coping skill in that context rather than simply assigning a new coping skill because it "fits" the therapist's life experience. Without understanding the cultural background of the clients, therapists are at risk of assigning treatment approaches that are more appropriate for their own life experience, rather than meeting the clients where they are and building on preexisting strengths. Both Sue and Sue (2013) and Paniagua (2005) have extensive chapters that address building cultural literacy with specific cultural groups. Many students are reluctant to make any assumptions about the culture of a client based on reading about the culture. For some, they fear that the result would be stereotyping. This is only partially true. When therapists make assumptions about a person based on what they see and read without collecting any individual information about the person, it is stereotyping. However, if therapists use preexisting cultural literacy as a foundation for working with a client (or population) and build the clinical relationships listening for within-group differences, it is not stereotyping. Rather, the recognition that there are within-group differences while also honoring

those historical patterns that influence the cultural context is adopting the fundamental principles of culturally responsive care.

Applying Multicultural Clinical Skills

The application of clinical skills within a culturally responsive framework is the core expectation for the multicultural therapist (Ponterotto, Casas, Suzuki, & Alexander, 2010; Sue & Sue, 2013). Expanding on the work of Ivey, Pedersen, and Ivey (2001), Jones (2009) refers to the application of culturally responsive skills as *multicultural intentionality*. To apply multicultural intentionality means to generate culturally responsive solutions to problems using multiple points of view—the client perspective, the cultural context, and the therapist's self-awareness. Multicultural intentionality allows the therapist to form intervention plans that consider a range of options that fit within the cultural context and work collaboratively with the client to determine which are the most suitable for their context. The cultural worldview, if appropriately analyzed and interpreted, will lead the therapist and client to a solution taking into account within-group cultural differences.

In the authors' 20 years of serving multicultural populations in clinical practice, one thing was quite clear—traditional approaches to treatment with children and adolescents of color are not always the best fit. Adaptations are usually necessary to integrate culture and cultural factors into treatment. Elements of evidence-based treatments such as cognitive-behavior therapy, dialectical behavior therapy, and applied behavior analysis are usually suitable for specific behaviors and disorders, but these approaches lack the guide for nurturing culture in the clinical relationship—a key component for collectivistic cultures. Recall that collectivistic cultures have a keen sense of community and connecting with others is a core belief. Therefore, any evidence-based technique should be grounded in the expectation that the therapeutic relationship and relationships with others are important aspects of the treatment process.

USING INTERPERSONAL THERAPY WITH CHILDREN AND ADOLESCENTS (IPT-A)

One evidence-based approach for treatment of adolescents that has been well supported in the literature is Interpersonal Psychotherapy for Adolescents (IPT-A; Mufson, Pollack Dorta, Moreau, & Weissman, 2004). IPT-A is an approach to treatment where symptoms (e.g., depression, anxiety, disruptive behavior) are evaluated in the context of interpersonal relationships. The focus on the treatment is on the interpersonal conflicts that result from the presence of symptoms and maladaptive responses to the interpersonal context. IPT is particularly appropriate for children and adolescents of color because interpersonal conflict is extremely troubling to people who operate from

a collectivistic orientation. The sense of "we" is more important than the "me" in interpersonal relationships. Thus, a treatment approach that focuses on improving the quality of interpersonal relationships will be healing and help the child or adolescent move away from maladaptive behaviors. With children and adolescents in general, the psychopathology is often most apparent at school in the presence of same-age peers and manifests in social relationships. Thus their relationships are more likely to be disrupted when a basic cultural value is inaccessible (collectivism). The following sections describe the treatment process of IPT-A and specific cultural adaptations that can be applied for the therapist to be culturally responsive. This approach will be referred to as Culturally Responsive IPT-A (CR-IPTa).

THE TREATMENT PROCESS

IPT-A includes three phases of treatment: the initial phase, the middle phase, and the termination phase. Within each phase, there are four sessions that are completed. The phases of treatment are introduced briefly below while this chapter adds specific adaptations to enhance the cultural responsiveness to the treatment approach. For specific detail about the individual sessions, see Mufson et al. (2004).

Phase I: Diagnostic Formulation and Diagnosis Education

According to Mufson et al. (2004), the first phase of IPT-A is on determining the appropriate diagnosis for the symptoms that the client is exhibiting and teaching the client about the diagnosis. The therapist conducts a thorough analysis of the symptoms, determines the interpersonal context of the symptoms, and works with the client on establishing guidelines for the therapy including the role of the parent and family in the process. The authors recommend interviewing and conducting an interpersonal inventory of significant relationships. This is a culturally responsive approach to understanding systems of support. Mufson et al. (2004) recommend taking the interpersonal inventory and linking to the symptoms to build a context for the client's relationships. The development of IPT-A was intended to be a universal approach to treatment, but this author recommends additional adaptations to place the diagnostic formulation in the cultural context. For Culturally Responsive Interpersonal Therapy with adolescents (CR-IPTa), these adaptations include: identifying the cultural context by assessing acculturation, assessing ethnic identity development, and conducting intentional multicultural interviews.

Identify the Cultural Context

One essential step to understanding cultural contexts is to determine the acculturation style of the client and their family. According to Berry (1990), acculturation is "the process by which individuals change, both by being influenced by contact with another

culture and by being participants in the general acculturative changes under way in their own culture" (p. 235). Berry's model of acculturation looks at client values across two dimensions: maintenance of native cultural identity and adoption of the values of the majority (or host) culture. Four predominant acculturation styles resulted from Berry's work: assimilation, separation, individualism, and integration. *Assimilation* is an acculturation strategy where the individual chooses to adopt the characteristics and values of the majority culture and relinquish the native cultural identity. *Separation* is the approach where the person prefers to maintain the native cultural identity and reject the values and characteristics of the majority culture. People who employ the *individualism* strategy are those who dissociate from both the majority culture and their native cultural identity. They have a preference of identifying themselves as unique and not connected with any particular group. Finally the *integration* is a strategy where the client chooses to adopt characteristics of the host/majority culture as well as maintain the native cultural identity (Berry, 2005).

Higher levels of acculturative stress are associated with some of the acculturation strategies. A study by Berry, Kim, Minde, and Mok (1987) showed that acculturative stress was most associated with the individualism (then called *marginalized*) group and the separation group. Berry (1990, 2005) found that those using the assimilation strategy also experienced intermediate levels of acculturative stress. In both studies, the group employing the integration strategy revealed the lowest levels of acculturation stress. Thus, assessing acculturation is a nuanced process that involves recognizing the aspects of culture that may be risk or protective factors.

One can assess acculturation through interviewing and direct questioning, observing adolescents in the social context, and/or using acculturation questionnaires. For example, the Acculturation, Habits, and Interests, Multicultural Scale for Adolescents (AHIMSA; Unger et al., 2002) is a scale that was developed to assess acculturation in adolescents. It is aligned with Berry's acculturation model and assesses adolescents' orientation toward U.S. culture and their home/native culture. The AHIMSA is a tool that can be used to discuss cultural values and acculturation patterns within and between family members.

Assess Ethnic Identity Development

When working with children and adolescents, it is essential for the therapist to consider not only the family cultural context, but also how the child is developing within the cultural context. In addition to identity development (e.g., increasing independence from parents), children of color are also developing their ethnic identity. There are several models of ethnic identity development that are specific to racial or ethnic groups including: Black Identity Development (Cross, 1991), Asian American Identity Development (Chae & Larres, 2010; Kim, 1981; Kitano, 1982), Latino American Identity

Development (Bernal & Knight, 1993; Miville, 2010; Ruiz, 1990) and White Racial Identity Development (Hardiman, 1982; Helms, 1995). Therapists can use these theoretical models to help assess where children may fall among stages of ethnic identity development within the context of their specific ethnic minority group. For the purposes of this chapter, one model of ethnic identity development will be discussed as it is designed to frame the development process across multiple racial and ethnic groups.

Atkinson, Morten, and Sue (1998) developed a conceptual framework of racial/cultural identity development (R/CID) that captures the complex interaction between the client's cultural background, life experiences, and the client's attitudes and beliefs toward others (Jones, 2009). The authors describe five stages of racial/ethnic identity development: (1) conformity, (2) dissonance and appreciating, (3) resistance and immersion, (4) introspection, and (5) integrative awareness. In the *conformity* stage, there is an unequivocal preference for the cultural values of the dominant group rather than for the values of the ethnic minority group. In the United States, White Americans are considered the "dominant" reference group, so in the conformity stage, an identification with White American values is preferred to the minority racial/cultural heritage. For a young African American child, this might manifest as a preference for White dolls, or asking to change their a name to a more Eurocentric name. The *dissonance* stage usually occurs after exposure to an event (or series of events) that challenges the client's self-concept because the ideas are inconsistent with their beliefs in conforming to the dominant culture. For example, a bilingual Latina female who has an all White peer group may feel completely disconnected from her native culture, but is reminded of her Latina status when her peers ask her to "speak Spanish and teach [us] about Cinco de Mayo." This student may experience dissonance after being exposed to a reminder of her heritage even though she does not identify with it. The *resistance and immersion* stage is the opposite of the conformity stage. Here, the clients endorse minority-based views and values and actively resist against the dominant culture. They are very culture-centered and prefer relationships with people from similar backgrounds. In the *introspection* stage, there is no negative attitude toward either the minority cultural group or the dominant group so the clients can objectively evaluate their views of the world. Emotional conflict occurs in this phase when the client recognizes that there are elements of the dominant culture that are functional and desirable, but the client is unsure how to incorporate these elements into the minority culture. For example, the concept of "selling out" to the minority culture/race is often a source of emotional turmoil for these clients. In the *integrative awareness* stage, the clients are able to accept and appreciate aspects of their culture as well as aspects of the U.S. or dominant culture. They see that there are both unacceptable and acceptable aspects of all cultures and they should examine all characteristics before deciding whether to accept or reject the cultural values. Sue and Sue (2013) outline

these stages in detail with examples of the client's attitudes and beliefs as well as the therapeutic implications associated with each stage.

Using a model such as the R/CID framework to understand the developmental progression of a client gives the therapist greater cultural literacy in the context of the individual client. Both identity development and ethnic identity development have a powerful impact on the social and emotional growth of adolescents. These two developmental processes interact simultaneously; therefore, they both warrant attention at all times. We can look at the child or adolescent from a variety of perspectives and understand the subtle issues impacting their daily decisions.

Multicultural Interview (JIMIS)

The *Jones Intentional Multicultural Interview Schedule* was developed to help prepare school psychologists to complete multicultural interviews (Jones, 2009; Jones, 2014). This interview method includes questions that facilitate discussion of cultural issues as they relate to stress and coping with children and adolescents. The interview questions also help the therapist collect relevant cultural information about the family within the cultural context. In addition to the questions that are asked for the interpersonal inventory, more direct questions about race and culture should be asked. These questions will allow the therapist to learn more about the client as an individual within the ethnic minority group. For instance, for a child or adolescent who is multiracial, the therapist should ask, "How do you identify yourself in terms of race?" "Whom do you feel the most connected to?" What experiences do you have with racial conflict?' Other questions can explore cultural values: "How does your religion or spirituality impact you every day?" "What are some differences in the ways that you relate to elderly family members?" or "What are some differences in responsibilities between men and women in your culture?" (Jones, 2009). By using multicultural interviewing techniques and targeted questions to assess acculturation, the therapist can set the tone for open discussions on cultural factors such as race and ethnicity, including the complicated dynamics associated with cross-cultural conflict. Simultaneously, therapists can gather insight into the values and norms of the child's home culture.

Contracting for the Focus of Treatment

At the end of the first phase of treatment, the therapist should contract with the client for primary and secondary focus of treatment. A culturally responsive approach to deciding on the primary and secondary focus is to consider the adolescent's acculturation style and the interpersonal conflicts that are occurring within that context (Canino & Spurlock, 2000). This narrows down the possibilities of topics while also helps the therapist remain targeted on the areas of greatest challenge. Take, for example, the student who is interacting with peers using an assimilation style of acculturation. With the

assimilation style, students may attempt to match the dominant cultural norms but their behavior may cause them to experience rejection from racially similar peers. They may experience intergenerational conflict at home because their family expects behavior that is consistent with the native cultural values. Thus, for this adolescent, the primary and secondary focus on treatment may be intergenerational conflict and social fit in peer networks. An adolescent using the *separation* style will likely need interventions that are solely based on cultural factors and cultural beliefs. Treatment may focus on cultural conflicts in peer relationships because their way of interacting may not be socially acceptable within the dominant culture (Jones, 2014). Treatment may also need to focus on culturally-based coping styles (e.g., spirituality) and the integration of family values into school-based interactions. On the other hand, adolescents who do not interact and operate under the *individualism* acculturation style may be socially isolated. This social isolation may be the reason why the adolescent is referred for treatment. With individualism, the interventions may need to focus on the emotions associated with feeling different, having low self-esteem, social isolation, and searching for identity. Finally, the *integration* acculturation style may indicate a need for a complex set of issues as a focus of treatment. Adolescents using this style may appear to be bicultural and adaptive, but that does not mean that they live without challenges. Treatment may focus on challenging family values, navigating multiple types of peer relationships, and cultural collisions—situations where they do not know how to act because multiple cultures are interacting simultaneously (Jones, 2009). These examples all show that understanding the client's acculturation style can be a useful guide for therapists in intervention planning and implementation.

Phase II: Facilitated Problem Solving

In the second phase of IPT-A, Mufson et al. (2004) recommend a process of problem solving. This includes clarifying the problem area(s), identifying effective treatment strategies for the particular problem, and implementing interventions that have the greatest potential to resolve the problem. The middle phase is highly collaborative and engages the adolescents in their own care by enabling discussions on topics of concern, monitoring the related symptoms, and using real-time enactments to process new ways of interacting. The authors of IPT-A emphasize discussion of feelings overtly and connecting all feelings to current interpersonal functioning. One example of a specific strategy for managing interpersonal difficulties is including family in a few of the therapy sessions. In IPT-A, the invitation to participate may include one or two sessions and the time would focus on relationship negotiation and clarification of expectations between family members. The therapist must be careful to focus on the identified problem area, the interpersonal context, and ensure that the discussions are constructive and future-focused. A culturally responsive adaptation to IPT-A is to have regular family

sessions as part of CR-IPTa. By including important people within the interpersonal context, the treatment is more likely to have a lasting impact where the family participants can be understood better and also engage in behavior change. In CR-IPTa, Phase II could involve split sessions where 30 minutes is for individual therapy and 20 minutes includes other family members. The following sections include topics and strategies to be included in CR-IPTa.

Ethnic and Sexual Identity in Treatment

As adolescents begin the process of individuation, the development of identity is a core component of daily living. Knowing "who I am" and "who I should be" are frequent thoughts of adolescents that need to be processed within and between people. Often, acculturation style impacts this process where the adolescent may pull away from family expectations, but also experience the pain of the acculturation conflict. While the adolescent seeks the integration style, the family may expect the separation style (a grounding in the native cultural values). This acculturation conflict may be emotionally distressful to the adolescent and cause the symptoms associated with the reason for referral. For example, when a young girl comes from a family where traditional gender roles include women marrying and maintaining the household as her primary goal, she may feel conflicted emotions when she is attending schools where seeking higher education is the norm. If she adopts the assimilation acculturation style, her family may perceive her as rejecting their culture and betraying the family. This is a stressful position for the adolescents who are seeking their adult identity. Thus, it should be a primary or secondary focus of the treatment.

Sense-Making in Social Interactions

Social interactions are complex. When they are interacting between and within different cultural groups, they may find themselves having a difficult time determining the appropriate course of action that makes them "fit in" the best. Subtle behaviors have different meanings in different cultural contexts. In some cultures, specific communication styles are seen as positive and empowering while the same communication styles might be interpreted negatively in other cultures. For example, in some peer groups, speaking loudly and being assertive are the appropriate behaviors in a specific social context. However, with other peer groups, showing a more passive communication style, using observation, and demonstrating respect for a social hierarchy are optimal for best "fit." This means that the adolescent who adopts a bicultural approach to interactions has to make constant shifts in behavior to match the social context. Similarly, one of these styles may be more consistent with how the adolescent interacts at home while the other is more consistent with the culture of the school environment. When the adolescent demonstrates behavior that is inconsistent with the communication style for a

particular social context, they may experience rejection by a peer group and not have the ability to understand what happened. By using the peer interactions in treatment as a microcosm for the adolescents' everyday experiences, the focus of intervention will be more targeted toward their needs and the subsequent goals will be more appropriate.

Treatment Strategy: Communication Analysis

A useful treatment strategy is to listen for culturally laden cues. Therapists need to listen carefully to the statements reported by adolescents and think from a cultural frame of reference. Benign statements might lead to indications of cross-cultural conflict or acculturation conflict even when the adolescent does not directly report the feelings. The following are examples of statements that might indicate cultural concerns of an adolescent:

"People Like Me Just Can't Get a Break"

The key words in this phrase *are* "people like me." These words suggest that the clients perceive themselves as different from the norm. The behavioral health professional would benefit from inquiring directly about the key words and meaning and following up with questions about the adolescent's experiences with racism and discrimination. For the therapist, it is important to recognize that it does not matter whether the experiences with racism are real or perceived by the adolescent. There are many researchers who have studied the relationship between perceived racism and health issues (e.g., depression) and health risk behaviors such as substance use (McHale et al., 2006; Sellers, Copeland-Linder, Martin, & Lewis, 2006; Sinha, Cnaan, & Gelles, 2007; Wills, Yaeger, & Sandy, 2003). The literature reveals that even perceived racial stress impacts health and mental health. Therefore, it is essential that therapists are open to discussions about race, difference, and the impact on the life of the client. Of note, it is the psychological impact of such experiences that should be the focus of the treatment rather than the storytelling of racially related experiences.

"My Family Thinks I Have Lost My Soul"

This statement gives an indication of the family perception of psychopathology. It may also show whether the family could value or devalue traditional approaches to therapy. In some cultures, therapy is reserved for the "insane" and those with serious mental illness. These same cultures perceive mental illness as disgraceful to the family and will avoid addressing the problem using Western-based approaches to care. For example, families with a collectivistic orientation will see themselves in the context of the child, and if the child has an "illness" it is reflective of the family. Thus, traditional family approaches to treatment would be the appropriate course of action. "Soul loss" is a

common interpretation of sickness in Hmong culture. In order to treat the sickness, the family may seek the help of a shaman to enact rituals for the return of the lost soul. Depending on the cultural values of the adolescent, a therapist with good cultural literacy would demonstrate an ability to explore cultural values in the context of the symptoms and determine a course of action that meets the client and family in their cultural context.

"I Have No Idea Who I Am or Who I Am Supposed to Be"

When coming from adolescents, this statement is complex because it can encompass a variety of challenges in identity. They may be questioning themselves in terms of racial/ethnic identity and/or sexual identity. Previous sections in this chapter described the ways in which racial and ethnic identity can be explored, but did not address sexual identity, which also warrants attention. In early adolescence, same-sex preferences may emerge and may cause emotional distress and identity confusion. For gay, lesbian, bisexual, transgendered, and "questioning" youth, social stigmatization may be directly impacting their mental health. For example, the gay, lesbian, or bisexual adolescent may be dealing not only with the development of their sexual identity but also the reactions of others within their social context. They may experience discrimination, prejudice, or even violence as a result of and in response to their sexual orientation. Bullying, including verbal and physical harassment, is a prominent problem among gay and bisexual male adolescents (Rivers, 2004) and those who have attempted suicide (Friedman, Koeske, Silvestre, Korr, & Sites, 2006). Similarly, adolescents of sexual minority status may also face the stressor of estrangement from their family due to their sexual orientation. It is notable that the complexity is even more enhanced when the student identifies as a double minority—an ethnic minority and a sexual minority. In that case, therapeutic relationship should include sensitivity to ethnic and sexual identity issues.

Not only should the therapist pay attention to the interpersonal challenges that are associated with sexual minority status, but also the internal experience of sexual minority adolescents. Such internalized difficulties may include role confusion, feelings of helplessness, anger, sadness, and/or low self-esteem. Facilitating a safe therapeutic environment for this discussion is essential as there may not be another place where they can explore their interpersonal relationships in the context of sexual orientation. When considering the detrimental and potential cumulative effects of social stigma, family estrangement, and other internalized experiences of these students, it is understandable that there is increased risk for emotional distress.

"My Worlds Collided Today"

Adolescents who feel they are leading bicultural and/or multicultural lives will make this statement. They are usually referring to the confusing situation where they are having

to shift between cultural norms in the same setting but they failed to adapt well to the demands of a complex situation. For example, in a racially and culturally mixed environment, a common phenomenon is same group identification. Daniel Tatum (2003) addresses the tendency for students to be drawn to peers of the same race or ethnicity in the school context as a part of developing their ethnic identity. Simultaneously, as students of color attempt to assimilate in an environment that has a White majority, they must learn to adapt to the norms of the majority group. Adolescents may be required to behave in one way with one group and shift to another style of communication with a different group. While these complex processes are occurring, the adolescent may feel "stuck" when they are exposed to different cultural groups at the same time. The inability to react or cope with such situations may lead to emotional distress for the adolescent.

"No One Understands Me"

This statement can indicate issues with language as well as communication style. For the adolescents where English is their second language, they may be dealing with the troubling pattern of literally being misunderstood. Frequent misunderstandings can cause individuals to "shut down" and isolate themselves away from circumstances that may lead to further misunderstanding (Jones, 2009). Communication style may also be a manner in which a person feels misunderstood. For instance, some cultures are considered high context (Sue & Sue, 2013) where nonverbal communication is a more powerful means of communication. Nonverbal behaviors (e.g., eye contact, gestures, proximity) are learned and there is meaning attached to each nonverbal "signal" within an interaction. The therapist needs to have an understanding of cultural norms for the context as well as the cultural norms of the adolescent.

"I'm Not Like Other Kids—I Don't Need Much"

In the United States, upper class status is associated with the accumulation of materialistic goods and wealth. By the time preadolescence has emerged, class status is deeply embedded into the student's psyche and they may seek higher ranking among the socioeconomic social strata. Adolescents who are from poor households may feel disconnected from peers on the basis of their financial circumstances alone. Therapists should incorporate socioeconomic status into the variables that may be impacting interpersonal relationships. Phrases such as "I don't need much" may indicate an adaptive coping mechanism, while also demonstrating that they perceive themselves as different. If the therapist finds that this topic is particularly distressful and impacting the self-esteem of the adolescents, the therapy can focus on building the students up from the inside out. For example, therapy sessions can focus on variables that are within their control including: their self-worth, the family value system, and the qualities that they contribute to the school, their family, and the community.

"I Am Not Light-Skinned, So I Don't Have a Chance with Him"

In African American and Latino cultures, there have been historical negative attributions associated with darker skin tones. In the times of slavery, the darker skinned individuals were more likely to work in the fields whereas lighter skin-toned individuals were assigned to roles inside the home—a higher status position among slaves. Similarly, among Latino Americans there are specific terms that are used to reference skin tone. For example, Latinos with dark skin may be referred to as *morenos* or *prietos* whereas those with light skin or kinky hair may be referred to as *jabaos* or *grifos* (Paniagua, 2005). The use of these terms only has meaning in the context of the client's experiences. If a parent perceives lighter skin color as more "acceptable" in U.S. society, darker children raised in the household may have identity conflicts or believe that they face more challenges in life than their lighter-toned siblings. For adolescents in the process of developing romantic relationships, their ideas about race and relationships may be directly connected to their self-esteem. Darker-skinned girls with their hair in braids or dreadlocks may feel that their relationship choices are limited based on their skin tone and how they choose to wear their hair. Thus, the therapist should assess the meaning of the statement in the context of the individuals and set goals related to building self-worth using characteristics that are under their control. In addition, asking questions that challenge the assumptions that are made based on skin tone alone is often an empowering activity for adolescents and adults alike.

Treatment Strategy: Role-Playing Alternative Interactions

Role reversal and role enactments are an effective approach for helping adolescents process difficult interpersonal situations in individual therapy. In addition to processing the individual emotions that are connected acculturation styles, adolescents can practice new approaches to complex situations with the therapist while keeping in line with the acculturation style that they prefer. For the adolescents dealing with intergenerational conflict, they may role-play a discussion with the therapist where they are processing a difference in acculturation style with their parents. The optimal approach in this situation is a role-reversal technique where the adolescent can demonstrate the conflicting reactions of the parent/family while the therapist can test out new communication techniques as they represent the adolescent. The same approach can be used to work through situations related to social fit, cross-cultural conflict, role confusion, and bicultural interactions.

Phase III: Termination

The termination phase focuses on a review of the previous two phases of treatment including a reminder of the strategies learned and the changes that have resulted from

the application of the strategies. In traditional IPT-A, this phase should last between two and four sessions (Mufson et al., 2004). Termination should also focus on future planning including how to handle interpersonal stressors when they reoccur. This phase of treatment is sometimes more difficult than the first phase because the adolescent has formed an attachment to the therapist and the therapy process has been the context for a safe interpersonal relationship. As a result, the beginning of the termination process should include discussing feelings associated with ending treatment. If the feelings they identify are much like the symptoms that initiated the referral for treatment, this is the perfect context to demonstrate how application of the therapeutic techniques can lead to healthy interpersonal interactions. The primary tasks of termination include: identifying successes, generalizing new behaviors to other situations, and planning for future treatment or maintenance.

Identifying successes is the easiest part of the termination process when many successful events occurred. When few exist, it is more important to focus on the small achievements that can lead to greater successes over time. Success can be interpreted as new interpersonal competencies or skills. This might include times when the adolescent was presented with a difficult situation but successfully handled the interpersonal conflict in an adaptive way that was also suitable for their cultural context. Success might also include the absence of negative interactions with others. Sometimes just acknowledging the reduced incidence of negative interpersonal situations is a therapeutic intervention in itself. Progress toward goals, even if they are not met yet, may also be interpreted as success. Taking the time to walk through the successes builds insight in adolescents and their families.

Termination should also include the discussion of the specific interpersonal strategies that were effective for the cultural context and produced change in the interactions between people. It is easier for adolescents to retain the skills when they have been practiced in the second phase of treatment and highlighted during the termination phase. The therapist who labels each skill while also soliciting definitions of the skills from the clients is more likely to highlight their strengths in a powerful way. Once these strategies are identified, the therapist and adolescent should take the time to brainstorm about how the strategies might be appropriate in the future. Encouraging the adolescents to predict challenging situations and practice applying the skills in new context increases the likelihood that they will use the skills as well as generalize the skills to multiple social contexts. For example, the therapist could use examples from treatment and suggest new scenarios that involve acculturation challenges similar to those that were presented early in treatment.

Depending on the treatment context, there may be limited opportunity to continue working with adolescents and their family beyond the first round of care. Together, the adolescent, the family, and the therapist need to decide whether additional care

is warranted to support further progress. If further treatment is warranted, a return to the second phase of treatment might be the approach to take by contracting for a new primary or secondary focus of treatment. In other situations, maintenance sessions may be set for the future. Mufson et al. (2004) describe maintenance as once-a-month sessions that occur over the course of a year to prevent a recurrence of symptoms (Mufson et al., 2004).

SPECIAL CONSIDERATIONS FOR SPECIFIC POPULATIONS

Earlier sections of this chapter show that acculturation, identity development, and cultural conflict are potential sources of distress that should be on the radar of therapists. The author applied a more universal approach to addressing cultural issues by describing concepts such as collectivism and multiculturalism as common constructs for consideration. In the sections that follow, the purpose is to identify social marginalization as a factor that may influence how and why a person from a particular group may interact in a particular way. There is a purpose to many of the cultural norms and beliefs, and to ignore the presence of such norms is to ignore part of the person's social makeup. It also invalidates the importance of group membership. Thus, what follows is a brief overview of common strengths and challenges that therapists should consider for some of the larger ethnic minority groups in the United States.

Strengths and Challenges for African Americans

Among the greatest strengths of African Americans are the cultural values associated with flexible family roles, kinship and community bonds, spirituality, and parental engagement in racial identity development. First, the predominant structure of the African American family has been described as matriarchal. Even in two-parent households, the mother tends to be the backbone of the household where rules are established and enforced based on her expectations. A protective strength of African American families is the flexibility in family roles where childrearing is provided by a number of people including grandparents, older siblings, cousins, and close friends (Hill, 1999). These individuals make up an extensive extended family network—which is a major source of emotional, social, and economic support (Sue & Sue, 2013). Similarly, there are informal kinship bonds that exist between African Americans that exist to sustain relationships. These are individuals who are not necessarily related by blood, but are considered part of the extended family (Jones, 2007). Spiritual and religious values are a well-established additional strength of African American families. Church participation provides opportunities for self-expression, community engagement, leadership, and comfort (Christian & Barbarin, 2001; Sue & Sue, 2013). Spirituality has also been shown to be a protective factor that is associated with resilience with African

American children and young adults (Jones, 2007; Watkins, Labarrie, & Appio, 2010). Finally, African American parents have been shown to be successful at assisting their children in the process of racial identity development and instilling positive self-esteem in their children despite chronic exposure to discrimination (Rockymore, 2008). This construct, referred to as *racial socialization*, is directly connected to parenting. Parents who address racism directly with their children and help them identify with their own race buffer some of the negative effects of discrimination (Fischer & Shaw, 1999).

The greatest challenge to be addressed in treatment with African Americans is likely to be the mistrust that results from chronic experiences with racism and discrimination (Obasi & Leong, 2009). Therapists have to be careful not to mimic the responses of the majority culture when issues of racism and discrimination are presented in therapy. Therapists should be aware of the existence of racial oppression and how patterns of oppression are sustained over time and continue to impacts generations of African Americans. Trust can be gained through acknowledgment that discrimination continues to persist, processing the client's reactions to racial oppression (Jones, 1985), and selecting strategies that are empowering and supportive of the client's cultural strengths.

Strengths and Challenges for American Indian/Alaska Natives

American Indian/Alaska natives are a heterogeneous group that is composed of 565 documented tribes (Sue & Sue, 2013). This diverse community of people is among the strong cultural groups with well-established and maintained cultural values. American Indians are from a collectivistic culture. According to Garrett (2006), the extended family is the basic unit for the American Indian family structure where children are raised by not only their parents but also relatives such as aunts, uncles, and grandparents who live in close proximity. Tribal social structure is an important variable to assess because a system of interdependence with the tribal community may influence any decision making for all members of the family. Of note, American Indian individuals see themselves as an extension of the tribe, and success of the individual is only measured in terms of whether the behaviors benefit the tribe (Sue & Sue, 2013).

Among the greatest strengths of American Indians are: a sense of spirituality, respect for traditional values, extended family networks, allegiance to the tribal community, respect for elders, and their respect for nature (Gilgun, 2002).

The historical and sociopolitical background of American Indians is the source of significant challenge, even in the present day. The historic disruption of families, the loss of land and resources, and the destruction of the American Indian population due to wars and disease make the experience of American Indians unlike any other cultural group. Knowing the history of persecution is essential to understanding cultural mistrust in society today. As American Indian families have spent generations reestablishing and restoring cultural norms and values, it is important to understand what style

of acculturation is being exhibited by the child and tribal community. This will help determine the most culturally responsive approaches to treatment. Garrett and Pichette (2000) identified five levels of cultural orientation that might be exhibited by an American Indian: traditional, marginal, bicultural, assimilated, and paratraditional. These acculturation levels are similar to those identified by Berry (2005) with the exception of paratraditional. Paratraditional is a style where individuals have adopted mainstream (dominant) cultural values, but they are making an effort to return to traditional values. As with other cultural groups, acculturation conflict may occur between family and within the tribal community. Most common is intergenerational conflict between elders and American Indian youth (Rieckmann, Wadsworth, & Deyhle, 2004). A child or adolescent may be pulled toward the pantraditional acculturation approach after becoming assimilated into mainstream society. This could be a source of emotional conflict. It is important for therapists to understand that for American Indians, spirit, mind, and body are interconnected. Mental illness is thought to occur when there is disharmony between these three connections. The focus on treatment is to be on restoring balance and achieving harmony between mind, body, and spirit.

Strengths and Challenges for Asian Americans and Pacific Islanders

There are vast between-group differences for the Asian American population in the United States. Asian Americans consist of 40 distinct subgroups of people who speak different languages, have different values, and different religions. In the United States, we define Asian American as the larger groups in the United States (e.g., Chinese, Koreans, Filipinos, Asian Indians, Japanese), immigrants from Southeast Asia (Vietnamese, Laotians, Cambodians, and Hmongs), as well as Pacific Islanders (Native Hawaiian, Guamanian, and Samoan) (Sue & Sue, 2013). Given the diversity among these Asian groups, it is impossible to make any generalizations about Asian Americans. Ideally, the therapist would study the history of the subgroup and determine common cultural values of the subgroup. Historical and current experiences of the subgroup are key to understanding the cultural mores and expectations of the family. Despite the diverse perspectives, Sue and Sue (2013) and Paniagua (2005) offer some variables that are common across many of the subgroups of Asian Americans. For example, one common variable is a collectivistic orientation. Instead of focusing on the needs of an individual, Asian families tend to seek goals that bring honor to the family and group. Traditional Asian families are hierarchical in structure with the patriarch at the top of the hierarchy. Children are expected to defer to their elders out of respect and obligation to the family. Parenting styles are more authoritarian, with little commitment to democracy and negotiation between parents and children. Much like American Indians, there is a holistic view of the mind and body so emotional distress may manifest in somatic symptoms

(Conrad & Pacquiao, 2005). Cultural strengths include the clear respect for elders and the collectivism orientation as a system of support for coping within the family unit.

Challenges for Asian American communities include racial identity issues and acculturation conflict. Assessing acculturation style is an essential step to understanding the Asian American client. Acculturation provides a window into the presenting problems and helps the therapist determine the most culturally appropriate course of action. Highly assimilated Asian clients tend to be more open to Western styles of therapy while more traditional families will require cultural adaptations to remain in treatment. Additionally, Asian Americans continue to experience racism and discrimination today (Hwang & Goto, 2009), so the therapist must focus on how to deal with racism and change the environment. In schools, this may mean developing interventions at the systems level to address discriminatory practices against students of color.

Strengths and Challenges for Latino/a Americans

Latino/a Americans include people in the United States with ancestors that originated from Mexico, Puerto Rico, Cuba, Dominican Republic, central or South America. The term Latino/a (masculine and feminine versions of the term) is one of many terms that are used to address the same population. The majority of Latinos self-identify by their country of origin rather than as Latino/a or Hispanic. However, for the purposes of this chapter, Latino/a is the most inclusive term to represent this population of people with subgroups in it. Collectivism is also a core cultural value for Latino Americans. Developing and maintaining interpersonal relationships are central to the culture (Hernandez, Garcia, & Flynn, 2010). Family unity, respect, and traditions are important aspects of life for Latino Americans. Much like African Americans and American Indians, the network of family is inclusive of not only blood relationships, but also informal kinship support networks (Jones, 2007). Family roles are well established where the father is the patriarch and responsible for the family while the mother is in a position of self-denial and sacrifice for the family. Children remain in the role of obedience until adulthood. Sustaining these roles is part of familisimo—interdependence among family and close friends. Spirituality and religion are also core beliefs that influence coping in Latinos and are usually affiliated with strengths.

Treatment with Latino families should focus on acculturation conflicts, experiences with racism and discrimination, and the stigma associated with psychological difficulties. To address these challenges, the therapist needs to explore the client's heritage and openly discuss views of therapy. Intervention strategies must incorporate behaviors that make sense and are familiar to the client and family by linking directly to the well-established values for interacting among people (e.g., personalisimo and familisimo). The degree of acculturation is important for the treatment of Latinos because

it can influence both attitudes toward counseling and prognosis for participation in treatment. Ethnic identity needs to be explored for youth and adults so that the context for acculturation stress can be better understood.

Strengths and Challenges for Arab and Muslim Americans

Arab Americans and Muslims are among another diverse group of people whose ancestry originates in the Middle East and North Africa. Only one quarter of Arab Americans are Muslims, and the majority is Christian (Jackson & Nassar-McMillan, 2006). However, prejudice leads many Americans to correlate the Arab ethnicity with the Muslim religion. Arab Americans are a heterogeneous group of people who represent at least 20 countries in the Middle East and Africa. The structure of families varies widely among Arab Americans depending on the acculturation strategy and the native country. In general, though, Arab American families value community and an identity that is centered on their culture and relationship with God. Among the strengths of Arab Americans are the collectivistic orientation, spirituality as a protective factor for stress, and resilience from consistent exposure to racism and discrimination.

There is a stigma attached to seeking mental health supports outside of the family system. Arab Americans turn to prayer and their relationship with God for spiritual cleansing and coping with stress. Common problems that may influence the need for mental health care are exposure to racism and acculturation conflicts between second-generation children and their parents. As with other ethnic minority groups, therapists must assess acculturation to determine the appropriate interventions to support a child or adolescent.

CASE STUDY: AMARA

When adopting a culturally responsive approach to treatment, it is often challenging to learn how to integrate individual cultural factors into the therapeutic process. Although many of the stages may appear to be intuitive, experienced clinicians understand that this is not the case. In fact, one must be quite intentional in integrating culture at every stage of treatment. The following section addresses the CR-IPTa model in the context of a specific case study.

Background Information

Amara is a Cambodian female in the third grade who attends a public school in a high socioeconomic status neighborhood. Amara was transracially adopted by her single mother when she was 3 years old after having lived with her biological family for 1 year and living in foster care for 2 years. Amara attended kindergarten and first and second grade at a public school in her neighborhood. Amara's neighborhood is

an upper-middle-class community with single-family homes and a few newer condominiums. There is very little racial diversity in the neighborhood. Amara was the only student of color in her grade for kindergarten through the second grade. At the beginning of her second grade year, her mother was concerned because Amara began having "rage episodes" at home when there was any mention of school. Additionally, when it was time to do homework, Amara's frustration tolerance was extremely low and she would "explode" at the mention of correcting her errors on homework assignments. None of Amara's anger outbursts (or any other behavior of concern) occurred at school.

Amara's mother sought the assistance of a psychologist and the school's learning specialist to determine whether she had a learning disability that was surfacing at this point in her schooling. Amara's teachers were surprised by the request, but were willing to support the mother's curiosity. Even though Amara's teachers did not have any concerns about her academic competence, the school's learning specialist completed an assessment of Amara's learning capabilities. This evaluation determined that Amara is bright and her academic skills were above average compared to her same age peers.

Assessing the Cultural Context

Simultaneously, the psychologist worked with the family to complete a multicultural intentional interview to determine all of the variables that might be impacting Amara at school and at home. The interpersonal inventory revealed that Amara and her mother were particularly isolated from their family and social network. Her mother has a few friends who are also adoptive parents who adopted children around the same age. However, with their busy lives between work and school, they had no social interactions with others for several months. Amara was unable to identify anyone who was a "friend" for the interpersonal inventory. She listed names and then dismissed them as "someone that is usually mean to me." She emphasized her desire to include her birth family in the inventory and only added her adoptive mother with prompting by the psychologist. Amara has not had contact with her birth family for 26 months despite her requests for contact. Over the next several sessions, the disrupted interpersonal relationship patterns were clearer. Amara's mother thought that Amara was not interested in spending time with kids from school because "they see each other enough." Amara's interpretations of the relationship patterns revealed a different story—she sought friendships, but experienced repeated rejection for being different from the other kids.

Amara was not able to articulate the rejection directly, but she could through stories of her experiences and her internalized thoughts. For example, she described situations where everyone in the class was invited to a birthday party (except her) and when she asked about it the peer said, "I didn't think you would be able to come because you eat different kinds of food than me. Don't you just eat rice and stuff like that?" This statement did not make sense to Amara because she eats lunch at school and brings the same

kinds of foods that the other kids have. An assessment of ethnic identity development revealed that Amara was at the level of conformity until she would be presented with statements or actions of others that set her into a state of dissonance. The dissonance was not anything she could understand and she internalized the experiences as rejection. Thus, she would withhold her feelings throughout the day and "lose it" in the evenings when she could not process it all.

Her differences were not only present at school, however; she was also reminded of her difference every time she was with her mother. Until people got to know her family, children and adults would ask, "Oh! That's your Mom?!" With her mother being White, Amara had difficulty initiating discussions about race and difference because she was afraid she would hurt her mother's feelings. Amara was constantly in a state of confusion and loneliness. She also said that her "Mom can't understand how it feels to be brown."

In this case, Amara and her mother were adopting the assimilation style of acculturation. In the past, there were very few discussions of Amara's native Cambodian cultural values, no exploration of the history of her native culture, and her life story was a true adoption story—a story that began at the point of her homecoming.

The Treatment Process

The treatment focus addressed two aspects of her interpersonal functioning: family and peers in the context of her psychological symptoms. The family component of her treatment plan included developing a life story that included her native heritage. Amara and her mother worked on building and understanding of the history of Cambodia, immigration patterns to the United States, cultural factors that are maintained across generations, and specific (known) details about her birth family in the context of culture. This work was intensive and challenging for both Amara and her mother because Amara had a difficult time expressing her feelings with proportional intensity. As she developed a better understanding of the meaning of her "rages" she was more able to align the emotion with the appropriate word and talk through the feelings more easily. Over time and with practice, culture and heritage became a regular part of family discussions and Amara's mother received more opportunities to process the confusion and rejection that Amara was feeling.

The peer component of the treatment involved changes in their social network. Amara's mother decided to add more experiences in Amara's weekends and evenings that allowed her to connect with a more diverse peer group. This changed Amara's behavior for the remainder of the school year, so that summer her mother decided to move Amara to a multiracial, multiethnic Catholic school in a diverse neighborhood. Although she and her mother live in a part of town that is not racially diverse, her mother chose to drive her 30 minutes away from home to be in a school where the students "look like her" and there is a "respect for diversity."

Termination and Follow-Up

In the new school setting, Amara showed adaptive behaviors at school and only occasionally had the outbursts at home. It became apparent that the open dialogue about race and culture had subsided. Amara reportedly would initiate such discussions when they were "too busy" to sit down and focus on the stories and the pictures. As an IPT-A maintenance strategy, the family set appointments on their calendar for their "family time." This included doing family art together, replicating memories, and doing symbolic things to connect with the Cambodian culture. They ultimately decided to save money each month for a trip to Cambodia. In preparation for this trip, they are practicing speaking Khmer and visiting a Cambodian community center.

Clinical Summary and Interpretation

The use of CR-IPTa was a crucial approach to treatment for Amara. Her mother's first instinct was to assume that an academic issue was causing the strong emotional reactions. Amara was not only exploding at home, but also having severe internalized emotions around peer rejection. Her experiences with rejection were connected to perceived racism given that they usually involved her "differences." Without completing the evaluation of ethnic identity development and acculturation style review, the psychologist would not have a sense of the complexity of her emotions. Treatment could potentially have focused on behavioral techniques and expression of feeling—without regard for the cultural conflicts that were feeding the behaviors. Thus, CR-IPTa facilitated appropriate clinical care that was grounded in the underlying treatment factors.

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This book presents a framework for understanding cultural identity. It shows how cultural variables interact to formulate ones identity. The author includes broad system level constructs such as class and region to demonstrate how cultural influences overlap. Additionally, the book includes culturally responsive strategies to be used with evidence practices.

Jones, J. M. (Ed). (2009). *The psychology of multiculturalism in the schools: A primer for practice, training, and research*. Bethesda, MD: National Association of School Psychologists.

This book addresses the influence of multiculturalism in the schools. It reflects on theory and addresses constructs of privilege and social justice in the context of inclusive school practices. The book offers practical suggestions for school psychologists to provide culturally responsive services in schools, research, and clinical settings.

Lopez, E. C., Nahari, S., & Proctor, S. (Eds.). (2015). *Handbook of multicultural school psychology: An interdisciplinary perspective* (2nd ed.). Mahwah, NJ: Erlbaum.

This book provides a unique look at the multiculturalism with an integrated lens. Implications for practice, training, and research are addressed throughout the book. The authors offer a balanced view of applications to assessment, interventions, and consultation. The book concludes with an interdisciplinary analysis of a multicultural future.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (2010). (Eds.). *Handbook of multicultural counseling* (3rd ed.). Thousand Oaks, CA: Sage.

The authors in this book offer a global approach to multiculturalism. The book is organized around the theory and practice of multicultural counseling using cutting age research and evidence-based approaches. The content is accessible to people new to the construct of multiculturalism, but also engages established multicultural clinicians in new approaches to treatment. One unique aspect of the book is the window into the personal and professional growth of leading researchers in multiculturalism.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: Wiley.

This text is the most cited reference in multicultural counseling and therapy. This book uses a sound conceptual framework to guide clinicians in counseling interventions in the context of specific cultures. The emphasis is on increasing cultural literacy with a wide range of cultural groups. The authors are sensitive to create a context for practice using universal approaches before narrowing down to specific populations. The book is grounded in empirical research, theory, and translates the content directly to practice.

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CHAPTER

4

Play Therapy

A Child-Centered Approach

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Since the early 1900s, mental health professionals have embraced the value of play in child therapy due to its developmental and growth producing properties. Play, a fundamental feature of childhood, is essential to children's brain development and holistic functioning (Perry & Szalavitz, 2006). Through play, children communicate and make sense of their experiences comparable to the way adults use words in "talk therapy" (Bratton, Ray, & Landreth, 2008; Landreth, 2012; Schaefer & Drewes, 2014). In play therapy, children also use play to explore relationships, build mastery, release energy, experience catharsis, develop coping strategies, and develop socially (Gil & Drewes, 2005; Landreth, 2012; Ray, 2011).

Although various theoretical models of play therapy have been developed in its more than 100-year history, Child-Centered Play Therapy (CCPT), based on Carl Rogers's (1942) person-centered theory, is not only the longest-standing play therapy modality in use today, CCPT is recognized as the most widely practiced (Lambert et al., 2007) and researched (Bratton, Ray, Rhine, & Jones, 2005) approach in the United States, and the approach has earned a strong international reputation (West, 1996; Wilson & Ryan, 2005).

HISTORY AND STATUS

Like adult psychotherapy, CCPT has its roots in psychoanalysis (Landreth, 2012). The first psychoanalysts believed that the root of adult personality problems was

the repression and sublimation into the unconscious of aggressive or sexual drives during childhood. Freud believed that the first 6 years of life are critical in personality formation, and that children's personalities are still in the process of development. Thus, working with children in psychoanalysis was considered a viable treatment method. Freud himself described his work with the father of "Little Hans," but his daughter, Anna Freud, developed the most well-accepted, clinically focused theory of psychoanalysis with children (Lee, 2009). Even before Anna Freud published her seminal work, Hug-Hellmuth, an influential child analyst and supporter of Sigmund Freud, began writing about children's dreams and the psychoanalysis of children (MacLean & Rappen, 1991). In her work, Hug-Hellmuth (1920) described the use of play in the analysis of children, not as a means of distracting them or holding their attention, but as a means by which the child could communicate to the analyst and the analyst to the child. Other psychoanalysts, such as Melanie Klein (1932) and Winnicott (1971), also developed approaches to child analysis.

Ginott (1961), another psychoanalytically-trained psychotherapist, also wrote on the importance of play in addressing children's developmental needs. Although Ginott's most well-known work on play therapy focused on group play therapy, his explanation of psychoanalytic theory, his instructions and rationale for setting up a playroom, and his discussion of techniques of the child therapist can all be applied to individual child analysis. Ginott emphasized the importance of allowing the children to take over the direction of the play so that they could express freely their inner conflicts and feelings. Similar to Hug-Hellmuth, Ginott believed that the adult's role in the playroom was to be interested and engaged, yet neutral.

Although a few directive play therapy approaches emerged in the first half of the 20th century (Hambidge, 1955: Levy, 1939), the humanistic movement was responsible for the advancement of the practice of play therapy, most notably through the nondirective approach developed by Virginia Axline (1947). Based on her belief in children's ability to solve their own problems and heal through their own self-growth process, Axline applied Rogers' (1942) person-centered approach to her work with children. Rogers' conviction in every individual's tendency towards self-actualization and positive growth was a cornerstone of Axline's nondirective play therapy. Consistent with Rogers' approach, Axline placed an emphasis on the relationship between the child and the therapist and on the importance of providing a supportive environment to facilitate the child's expression in the playroom setting. Axline popularized play therapy through the publication of the book, *Dibs in Search of Self* (Axline, 1964). Clark Moustakas (1959) developed a similar relationship-based play therapy approach and highlighted the importance of respecting the child's uniqueness, focusing on the present moment in the therapist-child relationship. Later proponents of nondirective play therapy, including Louise Guerney (1983, 2000) and Garry Landreth (1991, 2012), further refined

Axline's approach into what has become known in North America as CCPT, but continues to be recognized as nondirective play therapy in the United Kingdom and elsewhere in Europe (Bratton, Ray, Edwards, & Landreth, 2009).

A significant development in the application of CCPT was the development of filial therapy by Bernard and Louise Guerney in the 1960s (L. Guerney & Ryan, 2013). In this pioneering approach, parents received training and supervision in CCPT procedures to use with their children (B. Guerney, 1964). Building on the work of the Guerneys, in the 1980s Garry Landreth developed a more structured and condensed 10-session filial therapy training format (Landreth & Bratton, 2006), which has developed strong empirical support with diverse populations of families. Consistent with the Guerneys' model, parents in CPRT are taught child-centered play therapy (CCPT) principles, attitudes, and skills to use in weekly, supervised parent-child play sessions as a treatment intervention that impacts children and their families on a systemic level while addressing a range of problem behaviors and concerns. Landreth and Bratton (2006) formalized the 10-session training model in a text, *Child Parent Relationship Therapy (CPRT): A 10-Session Filial Therapy Model*, to distinguish the model from other filial therapy approaches. The CPRT protocol was manualized by Bratton, Landreth, Kellam, and Blackard (2006) to provide practitioners and researchers with a tool for ensuring treatment integrity in implementing the intervention.

The field of play therapy grew dramatically over the past three decades as numerous theorists, academicians, and practitioners developed specific play therapy approaches based on their theoretical views and experiences with children including gestalt play therapy (Oaklander, 1988), Jungian play therapy (Allan, 1988), Adlerian play therapy (Kottman, 1995), ecosystemic play therapy (O'Connor, 2001), cognitive behavioral play therapy (Knell, 2009), prescriptive play therapy (Schaefer, 2001), integrative play therapy approaches (Drewes, Bratton, & Schaefer, 2011), as well as approaches that espoused technical eclecticism. However, outcome research to support the efficacy of play therapy approaches other than CCPT is scant.

OVERVIEW OF CCPT THEORY/PHILOSOPHY

As noted earlier in this chapter, CCPT developed as a result of Axline's (1947) application of the principles of person-centered theory to children. As such, CCPT adheres to the basic assumptions underlying Rogers's theory of personality and recognizes the relationship between therapist and child as the primary mechanism of change.

Basic Assumptions

Rogers' (1951) 19 propositions serve as the framework for understanding human development and the structure of personality from a child-centered perspective. The child

is the center of a constantly changing world of experience and responds to the perceptual field, his or her reality, as an organized whole. Organismic experience includes all information available through the senses and through internal feelings. The child has one basic actualizing tendency to move toward growth and this actualizing tendency is expressed through goal-directed behavior. Behavior is accompanied and facilitated by emotion and is best understood from within the child's internal frame of reference. From a child-centered perspective, all thoughts, feelings, and behavior are understood as the child's best attempt to meet his or her needs and to maintain and enhance the experiencing organism.

As the child interacts with the environment, a part of the perceptual field is differentiated into the self-structure (Rogers, 1951). The self-structure allows the child to make predictions about the environment and how others will relate to him and provides a framework for the child to make sense of the world and find his place in his family, society, and culture (Tolan, 2012).

The self-structure is primarily developed in accordance with the values of one's parents or primary caregivers. As a child seeks to meet her need for positive regard, to be valued and accepted by others, she develops conditions of worth. Values that are not experienced directly by the child are introjected from others as if they were experienced directly. For example, a child falls and skins her knee and reaches to be hugged by her parent. As she cries and seeks comfort from her parent, she is told not to cry, pulled to her feet, and instructed to keep walking. Through this experience, the child learns, "I am only valued and accepted if I am strong and self-sufficient." She then denies or distorts her own experiences of feeling vulnerable and desiring comfort from others in order to protect her self-structure and to maintain love and acceptance from others. Throughout development, children's experiences are accurately symbolized and organized into the self-structure, ignored because they have no relationship to the self-structure, or denied and distorted because they are inconsistent with the self-structure.

Experiences that are inconsistent with how individuals see themselves, others, and the world are perceived as threatening to the self-structure. Under threat, the self-structure becomes more rigid in order to protect and maintain itself. When the self-structure is such that all of one's experiences can be accurately symbolized and integrated, the individual is able to abandon previously introjected values for an organismic valuing process.

Psychological Maladjustment

Within a child-centered framework, psychopathology is understood in terms of incongruence between one's self-structure (including one's self-concept and one's conditions of worth) and one's real experience. When one is unable to integrate one's real, lived experiences into his self-concept and value system and either denies, distorts, or ignores those experiences, he experiences psychological maladjustment. Incongruence between

the self-structure and real experience often creates "anxiety" or "vulnerability" (Rogers, 1957) that is most often demonstrated in children through problem behaviors (Ray, 2011). For example, if a child believes that he should be able to do his math homework without making mistakes and must be a perfect student in order to be valued and accepted by others, but has difficulty with multiplication tables, he may experience incongruence between his self-structure and his real experience. If the child is unable to integrate his real experience of struggling with multiplication because it is too threatening to his self-structure and denies his actual experience, he may get angry, burst into tears, and yell at his classmate for distracting him from doing his work. In this instance, the discrepancy between how the child sees himself and his real experience is expressed through externalizing behaviors towards his classmate. The more consistently and pervasively the child experiences incongruence between self-structure and actual experiences the more psychological tension and maladjustment the child may experience. This incongruence may be expressed through a variety of externalizing and internalizing behaviors.

Therapeutic Goals and Process of Change

The primary goal in CCPT is to provide a safe and accepting environment that allows the child to experience integration, self-direction, and growth. Rogers described the kind of nonthreatening environment necessary for individuals to integrate experiences into the self-structure through the six necessary and sufficient conditions for constructive personality change (Rogers, 1957).

1. Two persons are in psychological contact.
2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
3. The second person, whom we shall term the counselor, is congruent or integrated in the relationship.
4. The counselor experiences unconditional positive regard for the client.
5. The counselor experiences an empathic understanding of the client's internal frame of reference and endeavors to communicate this experience to the client.
6. The communication to the client of the counselor's empathic understanding and unconditional positive regard is to a minimal degree achieved (Rogers, 1957, p. 96).

The first condition refers to the necessity that the child and the counselor are in contact with one another in such a way that each individual is experienced by and makes a perceptual difference to the other (Wilkins, 2010). The second condition refers to the individual's state of tension resulting from incongruence between the self-structure and

one's actual experience. This state of incongruence often results in confusion, anxiety, and distress because there is a conflict between one's feelings and behavior and one's conscious desires.

The third, fourth, and fifth therapist-provided conditions of congruence, unconditional positive regard, and empathic understanding promote a non-threatening environment that facilitates the child's integration of his experiences into his self-structure according to his own organismic valuing process.

- *Congruence*. Rogers (1980) defined congruence as a close matching between the counselor's real experience, what is present in the counselor's awareness, and what is expressed to the client. Congruence includes the therapist's openness and attunement to her moment-by-moment experience and the counselor's genuine experience and expression of unconditional positive regard and empathy toward the client. The counselor's realness and congruence allows the child to learn to trust his experiences of the counselor. As the child learns to trust his experiences more and begins to make his own evaluations of self and the world, he moves toward greater integration between self-structure and his experiencing (Tolan, 2012). The counselor's genuineness within the therapeutic relationship is dependent on the counselor's own self-awareness, self-acceptance, and ability to have empathy and unconditional positive regard for her own experience (Cornelius-White, 2007).
- *Unconditional positive regard*. Rogers (1957) defined unconditional positive regard as warm acceptance of every aspect of the client's experience. Unconditional positive regard reflects the counselor's fundamental belief in the self-actualizing tendency and understanding that the child's thoughts, feelings, and behaviors are his best efforts to resolve the conflict between his experiences with his self-structure. Unconditional positive regard includes complete and total acceptance of both the child's struggle toward a more fulfilling existence and the many self-protective defenses the child uses to distance himself from the feared threat of other people (Bozarth, 2001; Mearns, 2003). Unconditional positive regard involves hearing and accepting the client's entire world including both his organismic experiencing and his self-structure and attending to all aspects, both positive and negative, of the child's behavior, play, and nonverbal and verbal communication.
- *Empathic understanding*. Empathic understanding involves both perception and communication as the counselor aims to see the child and the world as the child sees it and to sensitively communicate that understanding to the child. Rogers (1975) defined empathic understanding as a process of "entering the private perceptual world of the other and becoming thoroughly at home in it … being sensitive, moment to moment, to the changing felt meanings which flow in this other

> person, and … communicating your sensings of his/her world" (p. 4). The counselor's empathic understanding facilitates the child's awareness of and freedom to explore her own experiences, even those that have been previously denied or distorted.

The sixth condition refers to the child's perception of the counselor's empathic understanding and unconditional positive regard. The child's perception of the counselor's empathy and acceptance depends on the counselor's actual, congruent experience of empathy and unconditional positive regard toward the child, on the counselor's ability to effectively convey and communicate this experience, and aspects of the child's self-structure that may impact her ability to take in the counselor's empathy and acceptance.

EMPIRICAL SUPPORT

CCPT is supported by seven decades of continuous and credible research with diverse populations of children in school and community settings (Baggerly, Ray, & Bratton, 2010; Bratton et al., 2005; Bratton & Ray, 2000; Bratton et al., 2010; Lin & Bratton, in press; Ray & Bratton, 2010). More than 90 controlled outcome studies have explored its effectiveness and summarily concluded that CCPT approaches including filial therapy offer a viable and effective intervention for children across cultures.

As the need for identifying effective early mental health interventions in the United States (Bratton, 2010; New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, 2000) as well as other countries (Wilson & Ryan, 2005) has received national attention, the impetus to provide rigorous empirical support for interventions has grown. CCPT research has met the challenge with increased production of stringent research over the past two decades, with a total of 64 studies examining CCPT's effectiveness with a broad range of presenting issues; 38 studies examined the impact of CCPT delivered directly by professional play therapists and 36 studies investigated the efficacy of CCPT delivered by parents and other significant caregivers under direct supervision of a CCPT therapist using filial therapy methodology (Center for Play Therapy, 2014). Baggerly et al. (2010) provided a comprehensive, detailed review of individual contemporary research studies demonstrating CCPT's effects on children presenting with externalizing problems (including aggression, ADHD, and disruptive behavior in the classroom), internalizing problems, global behavior problems, anxiety, depression, academic achievement difficulties, speech problems, and stress in caregiver relationships.

Over the past decade, play therapy researchers produced multiple meta-analyses (Bratton et al., 2005; Lin & Bratton, in press; Ray, Armstrong, Balkin, & Jayne, in press), comprehensive systematic reviews (Bratton, 2010; Bratton, Landreth, &

Lin, 2010; Bratton & Ray, 2000; Landreth, 2012; Ray, 2011; Ray & Bratton, 2010), and responded to criticism that play therapy is not supported by sound scientific research (Baggerly & Bratton, 2010). CCPT studies comprised the vast majority of research identified in these reviews. In the largest meta-analysis of play therapy to date, Bratton et al. (2005) concluded from reviewing 93 controlled, outcome studies that play therapy including filial therapy demonstrated a large treatment effect of .80 (Cohen, 1988) on a broad range of childhood disorders and presenting issues. According to Bratton et al.'s meta-analysis, the effect sizes for humanistic/CCPT approaches (ES = .92; large effect) was larger than the effect size for nonhumanistic approaches (ES = .71; moderate effect).

Two recent meta-analyses focused exclusively on the efficacy of CCPT. Lin and Bratton (in press) used rigorous hierarchical linear modeling (HLM) methods to examine the overall treatment effect from 52 controlled outcome studies 1995 to 2010. Findings revealed a statistically significant overall effect size (ES = .47), indicating a moderate treatment effect for CCPT interventions. Ray et al. (in press) reviewed 23 controlled studies evaluating effectiveness of CCPT conducted in elementary schools. Meta-analysis results were explored using a random effects model and results revealed statistically significant effects for outcome constructs including externalizing problems ($d = 0.34$), internalizing problems ($d = 0.21$), total problems ($d = 0.34$), self-efficacy ($d = 0.29$), academic progress ($d = 0.36$), and other behaviors ($d = 0.38$).

In summary, the findings from individual studies, meta-analyses, and comprehensive systemic reviews provide a strong evidentiary base for CCPT's use in school and community settings. Current research indicates that CCPT can be successfully used in diverse sites, with a broad range of ages, with ethnically, culturally and socially diverse populations, and with different formats. There is considerable evidence that CCPT is effective with children throughout the span of childhood with a range of issues that prevent children's optimal functioning. The empirical support for CCPT's effectiveness cross-culturally is a particular strength and supports its wide applicability.

CCPT IN PRACTICE

Because children are in the midst of developing the ability to symbolize inner experiences into words, they require an alternative to relying on verbal communication to express their feelings and thoughts. Play provides the medium by which children can symbolize and express their inner experiences (Wilson & Ryan, 2005). In CCPT, children are provided play materials to allow them a developmentally responsive means to express their emotions and experiences concretely and symbolically. Through the child's play and verbalizations, the therapist is able to enter into the child's experience and gain access to the child's underlying feelings, needs, and desires. If for example, a child

is referred by her parents due to noncompliance and temper outbursts, the child's play may reveal feelings of confusion and powerlessness regarding her parents' separation. The therapist can provide for the child's safe expression of her feelings and experiences in the playroom while working with the parents to help them better understand and respond to the needs of their child.

According to Axline (1947), nondirective play therapy/CCPT is based on eight guiding principles. Axline noted that the therapist should (1) develop a warm, friendly relationship with the child; (2) accept the child exactly as he is; (3) facilitate an atmosphere of permissiveness so that the child is free to express self; (4) recognize and reflect the child's feelings in order to help him gain insight into his behavior; (5) honor the child's inherent capacity to solve his own problems; (6) allow the child to direct the therapy; (7) understand that therapy is a gradual process and should not be hurried; and (8) establish only those limits necessary to ground the child in the world of reality and make the child aware of his responsibility within the therapeutic relationship.

The Playroom, Toys, and Play Materials

According to Landreth (2012) the optimal playroom size should be approximately 12 by 15 feet, although an open space of any size may be used. For example, in the case of schools where there may be no dedicated space for a playroom, the counselor may create a portable play room with a selection of toys (Landreth, 2012). No matter the space, the therapist should be intentional about the play materials and toys. Toys should be carefully selected to facilitate (1) a positive relationship with the child; (2) expression of a wide range of feelings; (3) exploration of real experiences; (4) testing of limits; (5) positive image; (6) the child's self-understanding; (7) opportunities to redirect behavior that is unacceptable to others (Landreth, 2012). Additionally, toys should be representative of the cultural experiences of the child. Toys chosen for the playroom can be broadly divided into five types: nurturing toys, aggressive toys, toys related to real-life experiences, communication toys, and mastery toys. The arrangement of toys in the playroom should be intentional and displayed on shelving that allows the toys to be easily accessible and visible to children. Landreth (2012) provided a comprehensive list of toys, play materials, and equipment for a fully equipped playroom as well as a list of play materials to avoid.

Therapeutic Skills

The following verbal and nonverbal skills are considered essential to the application of CCPT theory to practice: (a) reflecting nonverbal behavior, (b) reflecting verbal content, (c) reflecting feeling, (d) facilitating decision making and returning responsibility, (e) facilitating creativity and spontaneity, (f) esteem building and encouraging, (g) facilitating relationship, and (h) limit-setting (Bratton, et al., 2009; Landreth, 2012;

Ray, 2011). CCPT skills are not to be applied mechanically. Rather, the therapist is responsive to the child's present needs and applies skills based on therapeutic intention. Nonverbal skills include being physically and emotionally attuned to the child, showing genuine interest, and a tone of voice that matches the child's affect. The therapist's response is made in a manner that is consistent with the child's developmental level. Tone and rate of response should match the intensity, degree of interaction, and the affect of the child. For example, if the child is quiet and focused on her task at hand, the therapist slows the pacing of responses to avoid disrupting the child's play or inundating the child with verbalizations that are inconsistent with the child's present experience.

Reflecting Nonverbal Behavior

Reflecting nonverbal behavior is a skill that entails responding verbally to the child's play behavior. For example, the child carefully lines up the animals from largest to smallest (without any verbalization). The therapist may reflect, "You decided to line those up from the biggest to the smallest." Reflecting nonverbal behavior requires the therapist to fully enter into the child's world and communicates to the child that the therapist is interested in and attentive to the child's play.

Reflecting Content

Reflecting content in play therapy shows acceptance of the child's experiences and actions. As in talk therapy with adults, the play therapist paraphrases what the child is verbalizing during the play session. For example, a seven-year-old child is playing out a scene with the dolls in the dollhouse and shares that she was excited that her best friend was spending the night at her house, but they had a big fight because her friend wanted to stay up past bedtime. The therapist responds matching the child's affect, "You were really looking forward to your friend staying overnight, but things didn't turn out the way you expected."

Reflecting Feeling

Reflecting feeling is an important relationship-building skill and requires a keen attunement to the child's present emotional experience. A child accidently knocked over a tower of blocks he had been carefully constructing for some time and loudly exclaimed, "Darn it!" then proceeds to forcefully knock the rest of the blocks down. The therapist responds with matched affect, "You are really frustrated with those blocks!"

Facilitating Decision Making and Returning Responsibility

Children have an opportunity to experience themselves as empowered and capable when responded to in a manner that promotes decision making and self-responsibility

(Landreth, 2012). In response to a child who asks if it is permissible to put water in the sand, the therapist facilitates decision making by responding, "In here, you can decide" or "that is up to you."

Facilitating Creativity and Spontaneity

In CCPT, a primary objective is to create an environment that allows the child the freedom to tap into her internal resources and creative potential, thereby developing the child's capacity to respond with greater spontaneity and flexibility. For example, a therapeutic response that facilitates creativity could be "You know *lots* of ways that you can make the dart stick to the wall" in response to the child telling you several ideas she has to make the dart stick (regardless of whether her ideas are feasible).

Esteem Building and Encouraging

Esteem building and encouraging responses are empowering and help children experience themselves as capable and worthwhile. This skill recognizes the child's effort rather than praising accomplishments. In response to a child who is trying hard to get the lid off of the can of modeling clay, but has not been successful, "you are working hard to get that off; you are really determined." Similarly, if the child succeeded in getting the lid off after working hard to get it off, the therapist may respond by saying, "you were really determined to get that off and you got it."

Facilitating Relationship

In CCPT, the child's experience within the therapeutic relationship is considered the primary curative factor, thus relationally-oriented responses are essential to the therapeutic process. Relational responses are always focused on both the child and therapist and communicate the intimacy of the relationship. Examples include, "You made that special for me" (child makes "special" pretend food and carefully serves it to you); "You wish we had more time together" (child tells you at the end of the session that you are locked in jail with him and neither of you can leave).

Limit Setting

Landreth (2012) proposed a method of limit setting designed to help the child develop self-control through an internal, decision-making process. The steps of the A-C-T model are: (1) **A**cknowledge the feeling; (2) **C**ommunicate the limit; and (3) **T**arget an acceptable alternative or choice. CCPT is structured for minimal limit setting. Limits are set as needed primarily to provide physical and emotional safety for the child and the therapist, to protect the playroom, and as a tie to reality. For example the child may want to wear the therapist's expensive prescription glasses; using the A-C-T model, the therapist

may respond "you would like to try on my glasses (convey empathy and understanding of child's feelings/desire/intent), but my glasses are not for playing with (communicate the limit)." "You can put on the glasses that are in the dress-up trunk," or if there are not any play glasses in the playroom, "There are lots of other things you can play with in here" (target acceptable alternative).

CCPT with Adolescents

Most people do not have difficulty believing that play is the most appropriate means of communication for children in early and even middle childhood, but what about adolescents? Are not they too old to play? CCPT therapists can utilize the same person-centered principles in working with adolescents as they do with children. They can work to communicate congruence, empathic understanding, and unconditional positive regard as well as facilitate the other aspects of an environment that is facilitative of growth (Rogers, 1957). Although the goal of play therapy and the child-centered play therapist's attitudes are the same for children and adolescents, play therapists need to hone their responses depending on the age of the child (Wilson & Ryan, 2005). Child-centered play therapists working with adolescents will need to be prepared to respond in a way that acknowledges the adolescent's increasing understanding of complex emotions and nuanced social relationships. Similarly, because of the increased social development of adolescents, child-centered play therapists will generally express congruence in more complex ways with adolescents than with children. Play therapists also need to adapt the environment for adolescents. For example, Wilson and Ryan (2005) suggest including clay, balls that are soft, playing cards, paints, pens, other drawing materials, and miniatures that can be used to create small scenes. The play therapist may also adapt the introduction to the playroom so that adolescents feel the same permissiveness offered to children (Wilson & Ryan, 2005). Adolescents may choose to talk or to work with the materials in the playroom. Their use of both mediums of communication may reflect their ambivalence of their identity as a child or adult. Preadolescents and adolescents who come to therapy are beginning to deal with identity issues, often on top of otherwise difficult circumstances. Additionally, child-centered group play therapy, discussed below, may be particularly appropriate for adolescents given the importance of their peer group (Bratton, Dillman Taylor, & Akay, 2014). Bratton et al. (2014) provided a detailed description of developmental responsive CCPT procedures for young adolescents.

CCPT with Very Young Children

Very young children, those under the age of 3, are another group for whom the traditional play therapy structure must be slightly modified. Child-centered play therapists often choose filial therapy as a treatment of choice for the very young (Ryan & Bratton, 2008).

As previously mentioned, filial therapy is a model of teaching parents to be therapeutic agents with their children (L. Guerney & Ryan, 2013; Landreth & Bratton, 2006; VanFleet, Sywulak, & Sniscak, 2010). The primary focus for early mental health interventions is on children's attachment with their caregivers because a secure attachment provides the child with a firm foundation for continued emotional health (Bratton & Ryan, 2008). For this reason, child-centered filial therapy is the treatment of choice for young children and is described later in this chapter.

Group CCPT Procedures

In group CCPT, the play therapist's role is that of a facilitator of emotional and physical safety rather than the director of activities (Landreth & Sweeney, 1999). The goals of group CCPT are the same as those of individual CCPT, with the primary goal being to provide an environment in which the child is free to follow the self-actualizing tendency and become a more fully functioning person. An understanding of the rationale for group CCPT is important when deciding whether group is an appropriate modality for a specific child. Group play therapy may help hesitant or extremely shy children take more relational risks with the play therapist because they see that their peers do not face negative consequences for freely expressing themselves (Ginott, 1961). The presence of another child in the room also provides a real life social situation in which children can try out new ways of being as they acknowledge new parts of themselves (Ray, 2011). The presence of another child also allows children to receive direct feedback about what is and is not socially acceptable. The facilitative presence of the play therapist allows the child to experience social feedback in as safe an environment as possible (Landreth & Sweeney, 1999).

The child-centered play therapist must make careful decisions about whether a child is appropriate for group CCPT (Bratton, Ceballos, & Webb-Ferebee, 2009). For the group to be successful, both children must have some desire to be included and accepted by other children. Additionally, when forming a group, the play therapist should consider the extent to which children have exhibited aggressive behavior that could hurt others as well as whether a child has a history of sexually acting out on other children. Although children who have exhibited these behaviors are not necessarily contraindicated for group, the play therapist would want to make an informed decision based on a thorough understanding of the child's situation. For example, a child who becomes loud, defiant, and physically assertive when angry would not be a good match for a timid, fearful child. However, the first child might benefit from another child who would stand their ground. Similarly, a timid child might be a good match for an outgoing but socially awkward child. Play therapists can conduct one individual session with the child as well as conduct an interview with the parent as screening measures for determining a child's appropriateness for group (Landreth & Sweeney, 1999). Age is another consideration

when forming groups. Generally, children in a group should be no more than one year apart so that they are at similar developmental levels and one child does not have a strong power advantage. The exception is for intact systems, such as sibling groups, in which a wide age range may be present. Additionally, children younger than 5 may be less likely to benefit from group play therapy because they tend to be less involved in cooperative play and less aware of the play of others. However, with preadolescents and adolescents, groups may often be the treatment of choice to address children's increasing need for peer acceptance (Bratton et al., 2014; Ojiambo & Bratton, 2014; Packman & Bratton, 2003).

Several considerations are important for the child-centered play therapist when deciding on the size of the group (Ray, 2011). Because the play therapist is intentional about providing the facilitative conditions to each child and taking a nondirective role, a group of more than two to three children may prove overwhelming because of the difficulty of fully attending to the emotions of so many children at one time. The noise level in the room with more than two or three children may also preclude the play therapist's ability to fully hear and understand each child. Additionally, the space required for more than three children to have the space needed to fully express themselves may be impractical for many play therapists. For younger children, smaller groups are more ideal (Landreth & Sweeney, 1999). Even for older children, groups of more than five are not recommended.

Brief CCPT

The advent of managed care and the nature of our "quick-fix" society necessitate a discussion about brief, or short-term, CCPT, which is defined here as 12 or fewer sessions (e.g. Johnson, 2001; Landreth, 2012). Although the concept of predetermining the number of sessions a child needs is at odds with the underlying philosophy of CCPT, a large number of sessions is not inherent in CCPT practice. For example, short-term play therapy has been shown to be efficacious with preadolescents with learning and behavioral difficulties and young children with behavioral and adjustment difficulties (Baggerly et al., 2010). Short-term, intensive CCPT, defined as more than one session per week, has been shown to be effective with elementary children with chronic illness and children living in a domestic violence shelter (Baggerly et al., 2010). Short-term group CCPT/activity therapy reduced the internalizing and externalizing behaviors of preadolescents (Flahive & Ray, 2007) and increased the self-esteem of a culturally diverse group of adolescent girls (Shen & Armstrong, 2008). CPRT, typically considered a brief or time-limited therapy, has been shown effective in reducing children's behavior problems, decreasing stress in the parent-child relationship, and increasing parental empathy in as few as seven play sessions. Children typically participate in seven weekly 30-minute play sessions with their parents while their parents participate in 10 weekly 2-hour sessions with a trained

CPRT therapist. Despite these and other studies that demonstrate short-term and intensive CCPT can be beneficial to children, Landreth cautions that the therapist must focus on allowing the child to direct the process of therapy and providing the conditions that facilitate growth, including not expecting rapid change from the child.

PARENTING APPLICATIONS

The importance of a secure parent-child relationship on children's socioemotional development and self-regulation has been well-documented (Perry & Szalavitz, 2006; Ryan & Bratton, 2008; Siegel & Hartzell, 2003). Filial therapy is a CCPT-based mental health intervention that focuses on strengthening the parent-child relationship while also providing emotional support for caregivers and increasing parental efficacy (L. Guerney & Ryan, 2013; Landreth & Bratton, 2006). The CPRT model of filial therapy training (Landreth & Bratton, 2006) is currently the most used and well-researched filial therapy approach with more than 35 controlled outcome studies demonstrating its effectiveness for a broad range of presenting issues, 19 of which are randomized controlled trials (Bratton et al., 2010). Founded on the filial therapy model of Bernard and Louise Guerney, at the heart of CPRT is the premise that a close parent-child relationship is the essential factor for children's well-being and that caregivers can be trained as therapeutic agents. Using the manualized protocol (Bratton et al., 2006), CPRT-trained therapists supervise parents in CCPT skills to use with their children in weekly special play times. In an accepting and supportive environment, parents learn to respond more effectively to their children's emotional and behavioral needs and effectively set appropriate limits on their children's behavior. In turn, children learn that they can count on their parents to reliably and consistently meet their needs for love, acceptance, safety, and security. CPRT has been successfully adapted and researched with teachers and mentors serving as the therapeutic agent. Morrison and Bratton (2010) developed a model for working with teachers and coined the term Child Teacher Relationship Training (CTRT). More information on filial therapy can be found in L. Guerney and Ryan (2013), and specifics on the CPRT and CTRT model of filial therapy training is described in detail in Landreth and Bratton (2006) and Bratton et al. (2006).

EDUCATIONAL APPLICATIONS

CCPT has a long and rich history of use in school settings dating back to the 1940s (Ray & Bratton, in press). An impressive base of historical and contemporary empirical research supports CCPT's utility in preschool and elementary settings. Since 2000, 13 randomized controlled studies (total of 558 participants across studies with a mean of 43 participants per study) have been conducted in school settings. Research indicated that

participation in CCPT resulted in positive outcomes for academic achievement (Blanco & Ray, 2011), disruptive behaviors including aggression and ADHD (Bratton et al., 2013; Garza & Bratton, 2005; Ray, Blanco, Sullivan, & Holliman, 2009; Ray, Schottelkorb, & Tsai, 2007), internalizing problem behaviors (Ojiambo & Bratton, 2014; Packman & Bratton, 2003), speech (Danger & Landreth, 2005), and functional impairment (Ray, Stulmaker, Lee, & Silverman, 2013). Using the CPRT and CTRT models described in the previous section, teachers and parents in school settings have been trained in CCPT skills to use with children identified as behaviorally and academically at-risk. CPRT has been successfully implemented in Head Start settings with low-income Latino parents (Ceballos & Bratton, 2010) and low-income African American parents (Sheely-Moore & Bratton, 2010). The principles and skills of CCPT have been successfully applied by CTRT-trained classroom teachers, primarily in Head Start settings with at-risk children (Gonzales & Bratton, in review; Helker & Ray, 2009; Morrison & Bratton, 2010, 2011).

CASE EXAMPLE

Mia is a 6-year-old female who lived with her adoptive mother, Ms. Marquis, who adopted Mia from China when Mia was 6 months old. Ms. Marquis is a 41-year-old European American woman who had never been married. Ms. Marquis reported that from what she knew, Mia had lived with a single foster family from birth to adoption and that the foster family was reported to have loved her and treated her well. Ms. Marquis told the play therapist that she and Mia had bonded right away. Ms. Marquis' mother, who did not live in the home, had cared for Mia until Mia was old enough to attend kindergarten during the present school year, and even then the elder Mrs. Marquis had continued to provide after-school care. However, she had begun to develop some health problems, and Ms. Marquis had recently enrolled Mia in an after-school child-care program. Ms. Marquis reported that Mia had always been clingy and beginning school had been a challenge for her, but that Mia's clinginess had increased significantly in recent months to the extent that Ms. Marquis was having difficulty accomplishing daily tasks around the house because Mia wanted her attention and presence constantly. Mia had also begun having meltdowns at school.

The therapist was Nate, a 33-year-old Caucasian male who had 8 years of experience in counseling children with a specialty in working with children who had a history of interpersonal trauma. Nate was a licensed professional counselor, certified school counselor, and trained in CCPT. He maintained a private practice and was employed by the school district as a mental health specialist. He currently participated in a monthly

peer supervision group. Nate conducted play therapy with Mia at his private practice, although his playroom at the local elementary school was equipped identically to the playroom in his office (Landreth, 2012).

After an initial consultation with Ms. Marquis, Nate began seeing Mia in individual play therapy. At first, Mia did not want to go to the play therapy room with Nate. However, he did not pressure her to go, but reflected her fear of going with him. Based on Mia's history, Nate had previously prepared Ms. Marquis to accompany Mia to the playroom in the case Mia had difficulty separating from her mother. After the first few sessions, Mia looked forward to coming to see Nate and went easily to the playroom with him. During her first few play therapy sessions, Mia was hesitant to play, spending most of the time playing with the sand. When she began playing with the other toys, she carefully took one toy off the shelf and then replaced it before getting another toy out. In the early sessions, her play mostly reflected themes of mastery with toys that were easy for her to use and to control. For example, she often sorted the kitchen utensils, organized the dollhouse, or sorted the money. As Mia became more comfortable and confident, she began to expand her play to more difficult activities at which she did not always easily succeed. However, the therapist noticed that Mia rejected all of the therapist's responses to negative feelings. For example, if the therapist said, "You're frustrated with that," Mia would reply with an emphatic, "No!" and then throw down the toy and move to something different. The therapist conceptualized this response as Mia having difficulty symbolizing her experience of "failure" into her awareness. In his consultations with Ms. Marquis, Nate maintained Mia's confidentiality by not sharing specific details of Mia's play, but he did consult regularly with Mia's mother regarding Mia's play themes. For example, Ms. Marquis confirmed Nate's guess that Mia struggled with perfectionism and low-frustration tolerance at home and school. Nate encouraged Ms. Marquis to examine her own direct and indirect communication to Mia about the value of being perfect. He also requested permission to speak with Mia's teacher about whether her meltdowns at school were associated with Mia's perceived failures.

As the sessions progressed, Mia continued to deny or ignore most of the therapist's responses to her feelings of frustration or anger associated with "failure"; however, her ability to symbolize her difficulty into her experience seemed to be increasing as she would not throw toys down as frequently as before. Mia also began to play out scenes with the animals, mumbling under her breath with her back to the therapist. At first these play scenes took up only a few minutes of the session, and Mia would immediately change to a new play when the therapist responded to her use of the animals. Soon, however, they began to take up most of the sessions. At this point, Nate found it was necessary for him to work through his own feelings of rejection by Mia. Clearly this play

was very important for her, but because she turned her back toward him, Nate felt she did not trust him enough to allow him into her play. Nate felt he was a trustworthy person, and it was difficult for him to accept her decision or need not to share this aspect of her play with him. Although Mia did not actively involve Nate in her play, she began to verbalize the animals' conversations and actions more clearly and it became apparent to Nate that the child animals continually were being separated from the adult animals. Sometimes they were separated because of tragedy and sometimes they were separated as punishment. Regardless of the reason for the separation, Nate began to guess that Mia feared that any separation from her mother would be permanent and that if she was not good, she could be separated from her mother—a fear that seemed to be confirmed by Mia's recent separation from her grandmother who had served as a primary caregiver since she was an infant. This conceptualization fit with Nate's earlier experience of Mia having difficulty symbolizing "failure" into her self-structure. If failure or being bad meant she could be separated from her mother, then it did not feel safe to symbolize those feelings. In play therapy, Nate began to respond to the child animals' fears in a way that was consistent with what he saw as Mia's fears. Although Mia still sometimes rejected his reflections, she did appear to more easily accept responses to the animals than responses to herself. Perhaps Nate's responses to the animals were less threatening to her self-structure. Nate did not discuss Mia's animal play with Ms. Marquis, but he did enquire about Ms. Marquis' methods of discipline at home. Nate suggested Ms. Marquis avoid using time outs in which Mia was expected to stay in a separate room alone as these measures reinforced the idea that if Mia was naughty, she would be separated from her mother. Instead, he suggested that Ms. Marquis use "time in" with Mia when Mia was struggling behaviorally. In those instances, Nate instructed Ms. Marquis to reflect Mia's feelings and remove her from the situation using an established routine such as holding her and rocking while they read a favorite book together.

Overall, Mia's ability to symbolize negative aspects of herself into her self-structure appeared to be increasing. Furthermore, Ms. Marquis reported her meltdowns at school and home had diminished significantly and that she was somewhat less clingy at home. Furthermore, Nate still felt that Mia was primarily using the therapeutic environment to explore her attachment with her mother. Therefore, Nate decided to transition to filial therapy in which he would teach Ms. Marquis to provide a therapeutic environment for Mia during 30-minute weekly special playtimes. Ms. Marquis seemed amenable to this plan, so Nate let Mia know they would end their individual play times after 5 more weeks. He wanted to give Mia time to work through the ending of their relationship. Although Nate felt sad to end his relationship with Mia, he was optimistic that giving Ms. Marquis tools to interact therapeutically with Mia would help Mia feel more secure in her relationship with her mother.

CONCLUSION

Although play therapy has evolved since its origins a century ago to include various treatment approaches grounded in the developmental and therapeutic powers of play, CCPT approaches continue to be the most used by practitioners (Lambert et al., 2007) and the most widely researched (Bratton et al., 2005). This chapter focused on the theory, research, and practice of CCPT. Just as in person-centered therapy with adults, CCPT emphasizes the primacy of the therapist-client relationship as the mechanism of sustainable change. According to Axline (1947) and Landreth (2012), the therapist develops a warm, friendly relationship with the child, accepts the child as he/she is, creates an atmosphere of permissiveness, recognizes and reflects the child's feelings, acknowledges the child's capacity to solve problems, does not direct the child's actions, sees therapy as a gradual process, and establishes minimal limits. Through the symbolism and concrete nature of the play materials, the child is free to communicate all feelings, thoughts, and needs and move toward emotional and behavioral health. In order to enhance the effectiveness of play therapy, the child-centered therapist sees the child within the context of a support system, and thus works with parents to help them increase in their understanding of their child and become more invested in the play therapy process. CCPT has demonstrated its efficacy with a broad array of presenting issues in various settings. CCPT is unique in that its principles and procedures have been shown effective when applied by mental health professionals and shown equally effective when practiced by caregivers under the supervision of a mental health professional trained in play therapy. Its broad appeal and usefulness as a treatment modality is further evidenced by its successful application with diverse populations of children.

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CHAPTER

5

Cognitive-Behavioral and Behavioral Approaches

RICH GILMAN AND KATHLEEN CHARD

Cognitive-behavior therapy (CBT) is a broad classification that incorporates several specific models, many of which are reported in detail elsewhere in this book (e.g., *Rational Emotive Behavior Therapy, Reality Therapy, Person-Centered Approaches*). Other models that adopt aspects of CBT include *Self-Instructional Training* (Meichenbaum, 1977), *Dialectic Behavior Therapy* (Linehan, 1993), and *Acceptance and Commitment Therapy* (Hayes, Strosahl, & Wilson, 1999). Although these various models were first designed and applied to adults, many of their techniques have been refined and modified for use with children and adolescents (see Kendall, 2011). The purpose of this chapter is to discuss the use and efficacy of CBT on specific child and adolescent difficulties. General concepts of CBT are discussed, although primary focus is placed on Beck's *Cognitive Behavior Therapy* (e.g., A. T. Beck, 1967; J. S. Beck & A. T. Beck, 2011) to avoid redundancy with other chapters. We also acknowledge that the literature on CBT is vast, with virtually thousands of studies focusing on youth samples. Readers interested in understanding the nuances of CBT in general are referred to Wright, Basco, and Thase (2006), and J. S. Beck (2011). Likewise, readers are referred to Kendall (2011) to learn more of CBT as generally applied to children and adolescents.

A key tenet underlying all CBT models is that individuals' thoughts, attitudes, and perceptions about themselves and others influence their interpretation of an external event, and this interpretation subsequently influences a chain of emotional and behavioral responses. Factors such as personality, learned history, and access to internal

(e.g., coping strategies) and external resources (e.g., social supports) have been shown to moderate the valence of an experience. For example, students who receive a failing grade in a subject will interpret the news based on their previous history of success or failure in that subject, the type of support provided by teachers and parents (e.g., supportive versus punitive), personality characteristics (e.g., extraversion versus neurotic), and how they coped with previous failure in that subject (e.g., adaptive versus maladaptive). Students who receive a failing grade but have a poor learning history in that subject, less than adequate social support, and a sense of pessimism about that subject may view the grade as another indication of their gross incompetence, which may elicit strong negative emotions and maladaptive or distorted cognitions (e.g., "I'm stupid"; "I always fail at this")—all of which may contribute to their continued aversion to the subject or avoiding it altogether. Conversely, other students receiving the same grade but having a positive learning history, strong support by teachers and parents, and an optimistic sense of self may be disappointed, but the experience would not likely lessen their perceived competence or negatively affect future pursuits in that subject. In this regard, cognitive therapists maintain that it is not the event itself but rather the cognitive interpretation of an event that establishes the probability for a given affect or behavior. Further, the relationship between cognitions, affect, and behaviors is viewed as reciprocal rather than linear: The "incompetent" student would most likely avoid taking similar subjects in the future, and the absence of further pursuits in that subject not only minimizes the probability of eventual success but also reinforces their poor self-perceptions in that subject. Given this interaction, both cognitions and behaviors are simultaneously targeted in CBT.

Cognitive-behavior therapy seeks to enhance an individual's awareness of their cognitive misperceptions (i.e., distortions) and of the behavioral patterns that reinforce and are reinforced by these distortions. It is to be emphasized that not *every* distortion is targeted for therapy—everyone distorts an aspect of objective reality in some fashion. Only distortions that are creating the most distress to individuals and their significant others are targeted for intervention. The essential goal of CBT is thus to have the individual acquire adaptive coping strategies as well as improve awareness, introspection, and evaluation skills.

HISTORY AND STATUS

As a definable paradigm in psychology, CBT is relatively new, although its genesis can be found in the writings of Plato, Marcus Aurelius, Emmanuel Kant, and others, all of whom viewed reality as a subjective phenomenon based on a series of learned associations. The philosophy of CBT is noted in the earliest works in psychology, including those of William James (1909), and even early psychoanalytic theory. For example,

Adler believed that the underlying motivation for behaviors was due to an individual's thoughts and emotions surrounding an event, rather than to the event itself (Sperry, 1997). Given that psychoanalytic theory dominated most of psychological thought in the first part of the 20th century, it is not surprising to find that many of the pioneers in CBT were first trained as psychoanalysts, including Albert Ellis and Aaron Beck (Leahy, 1996).

Learning theory began to slowly compete with psychoanalytic thought during the early-to-middle part of the past century. Beginning in 1920 with the classic study by Watson and Rayner (1920), researchers began to view human behavior emanating from basic drives and learned behaviors, as opposed to underlying unconscious motives. This school of behaviorism flourished in the 1950s due to Dollard and Miller (1951), who integrated psychoanalytic theory with learning principles; the publications of B. F. Skinner (e.g., Skinner, 1953), which demonstrated that learning can be attained through stimulus-response methods; and Wolpe's (1958) application of stimulus-response conditioning to treat anxiety among adults. Many of these pioneering behavioral techniques are still applied today.

Nevertheless, toward the end of the 1950s, many theorists and researchers questioned how psychodynamic and learning theory could adequately explain the complete spectrum of human behavior and motivation. Long-term examination of unconscious drives and ego functioning and short-term application of classic and operant behavioral strategies could not fully address covert behaviors such as obsessions, depression, or generalized anxiety. During this time, other psychologists also became interested in how individuals construct their worldview through their own perceptions of reality. For example, Kelly (1955) asserted that individuals often categorize their experiences into dichotomous schemas (e.g., "good" versus "bad," "strong" versus "helpless"), and embracing one particular schema often makes it difficult to accept the alternative (Leahy, 1996). Finally, researchers in the late 1950s through the following decade also explored how individuals processed external information using cognitive mediators. Classic works by psychologists such as Albert Bandura (Bandura, Blanchard, & Ritter, 1969), Arnold Lazarus (1966), and Fritz Heider (1958) demonstrated that behaviors can influence and be influenced by select cognitions.

These early works as well as many others served as the conceptual foundation for the burgeoning field of CBT, and credit for applying cognitive psychological principles to solve clinical problems is often given to Albert Ellis (1962) who asserted that psychological distress was due to irrational thought distortions such as "I should," as in "I should be liked by everybody." Other early prominent clinicians and theorists included Donald Meichenbaum (1977), who used CBT to modify distorted thought patterns and stressful environmental influences; Martin Seligman and colleagues (Abramson, Seligman, & Teasdale, 1978; Seligman, 1975), who applied CBT to develop a model

of depression labeled *learned helplessness*; and Michael Mahoney (1974), who applied cognitive-behavioral principles to enhance self-control. Perhaps the most comprehensive model of CBT (and certainly one of the most influential) is based on the work of Aaron Beck (1967), who initially used CBT to work with adults suffering depression. In the past four decades, Beck's version of CBT has been used to explain and treat many forms of psychological distress among both adults and youth.

OVERVIEW OF THEORY

Basic Theory and Assumptions

As noted earlier, cognitive-behavioral therapy draws on cognitive, behavioral, psychodynamic, humanistic, and biopsychosocial theories. In addition, CBT for youth incorporates learning and developmental theories, acknowledging the importance of the impact of the individual's developmental level of self-control, social cognition, learning and memory, metacognitive skills, and attributions on treatment. Regardless of age group, Dobson and Dozois (2001) noted that all CBT models share three fundamental assumptions:

1. *Cognitive activity affects behavior*. Cognitive-behavioral therapists believe that a client's cognitive appraisal of events can affect their response (e.g., behaviors) to the events.
2. *Cognitive activity may be monitored and altered*. This global assumption contains two underlying assumptions. First, the therapist and client have access to the client's thoughts. Second, once all cognitions are explored, the client is better prepared to modify or change some of the more problematic (or distorted) ones.
3. *Desired behavior change may be created through cognitive change*. Borrowing from Mahoney's (1974) mediational model, modifying distorted cognitions alone changes the clients' interpretation of events, which in turn increases the probability that their behaviors will be altered in response to this new interpretation. This assumption does not dismiss the belief that overt reinforcement contingencies can alter performance (e.g., the use of tangible reinforcers to shape new and desired behaviors), but suggests that cognitive restructuring can be an equally valid method to create meaningful and lasting behavior change.

Given these assumptions, the task of the cognitive-behavioral therapist is thus to help the clients (1) become aware of their distorted cognitions, (2) identify the way these distorted cognitions are related to the clients' negative feelings and behaviors, and (3) modify their distorted thinking and maladaptive behavior patterns, both of which have heretofore reinforced and maintained their negative view of self and others.

In successfully completing these tasks, it is assumed that individuals will perceive and react differently to events, thus leading to less psychological distress and a more positive life outlook.

It should be mentioned that not all psychotherapies are considered to be in the cognitive-behavioral paradigm. Given that targeting cognitive distortions is the hallmark characteristic of CBT models, therapeutic modalities that exclude exploring and/or challenging cognitive distortions would not be labeled as CBT. For example, therapies that use behavior principles but do not contain an active cognitive mediation component (e.g., habit reversal) would not be classified as CBT. Similarly, therapies that focus on processing negative affect but exclude exploring and challenging related distorted thoughts (e.g., emotional catharsis models) also would not be considered as a CBT per se.

View of Psychopathology

Cognitive-behavioral theorists believe that human beings are not always accurate in their cognitive interpretations of events, and these distortions can be based on psychological, social/cultural, biological, and genetic factors (A. T. Beck, 2008; Dowd, 2003; Muris & Field, 2008). For the most part, such distortions are universal, relatively benign, and in many cases key to healthy functioning and life quality. For example, there is some evidence to suggest that maintaining unrealistic but positive views of self and others (i.e., positive illusions) may be a protective barrier against severe illness (e.g., Taylor, Lerner, Sherman, Sage, & McDowell, 2003), an important component of positive romantic relationships (Gordon, Johnson, Heimberg, Montesi, & Fauber, 2013), and may be an important coping mechanism among children with learning difficulties (Heath, Roberts, & Toste, 2013). Nevertheless, there are occasions when the cognitive distortions become so skewed that they significantly and negatively interfere with an individual's adaptive functioning across important life domains. It is on these occasions that various forms of psychopathology are observed.

Cognitive-behavioral therapists who assume A. T. Beck's (1967) perspective focus on distortions surrounding the clients' sense of themselves, their environment, and their future (often referred to as the *cognitive triad*). For many psychiatric disorders, distortions can be noted across each component in the triad. For example, individuals who are depressed often perceive themselves as lacking personal competence, view their past and current failures as continued evidence of their incompetence, and place little hope on a pleasant future. Individuals who are anxious often view themselves as unable to handle their distress, perceive elements in their immediate and distal environment as dangerous and threatening, and view their future with fear and apprehension. Finally, individuals with externalizing disorders (e.g., conduct disorder) often view (a) themselves as being treated unfairly or abused in some way, (b) others as unfair or interfering with their

personal goals, and (c) any future goals as inevitably being impeded by others (Alford & Beck, 1997).

GENERAL THERAPEUTIC GOALS AND TECHNIQUES

Given their conceptualization of psychopathology, cognitive-behavioral therapies are largely organized into three different categories: (1) coping skills therapies, (2) cognitive restructuring therapies, and (3) problem-solving therapies. Coping skills therapies focus less on changing cognitive interpretations of events and more on developing and practicing behavioral strategies and skills (e.g., use of relaxation strategies or assertive skills) to help the client deal with stressful situations. In contrast, cognitive restructuring therapies focus on modifying and replacing maladaptive cognitions with adaptive thought patterns, with relatively little focus on skill acquisition. Finally, problem-solving therapies can be viewed as a combination of the earlier approaches, with the goal being to simultaneously modify the client's maladaptive thoughts and create strategies that promote positive behavior change. A majority of contemporary CBT models fall into the problem-solving category.

Each CBT session typically follows an established framework, although the content in each session will change from person to person depending on the referral problem. Each session emphasizes a collaborative problem-solving approach that requires both parties to be actively involved. In addition, the client is often reminded that the therapist should not be viewed as the "keeper of the answers." Instead, all beliefs and perceptions are tested through a process labeled *collaborative empiricism*, whereby a situation experienced by the client is tested against the clients' interpretations of their self, worldview, and future. Using the example of the children who receive a failing grade and perceive themselves as incompetent in that subject, the therapist will help the children test their interpretation of the event against competing and supporting evidence (e.g., Was there ever an occasion when the youth received a passing grade in that subject? Has the youth always done poorly in that subject?), and against each element in the cognitive triad (e.g., How important is the subject to the child's sense of self? How accurate are the children's perceptions that there are little positive social support when they fail? How entrenched is their belief that they will never receive a passing grade in that subject?). Keywords such as *always* ("I always fail this subject"), *never* ("I'll never pass"), and *should* ("I should just quit school") are listened for and immediately attended to by the therapist during the course of the discussion.

Each session also follows a sequential procedure that further strengthens the alliance between the client and the therapist. If the treatment is manualized, the agenda will be somewhat more structured than nonmanualized approaches, but in both cases there is room for flexibility. The first step is *setting the agenda*, or a discussion of what will be

covered during the session. The second step is a *review of the client's homework assignment* that was given in the prior session, which is designed to have the client practice skills in vivo. Impediments toward completing the homework are examined and addressed if necessary. This review is often followed by *goal setting*, or what the client should expect from the current session. After goal setting, *a new skill is taught and practiced*. This skill is often based on what was learned in prior sessions and is conveyed through didactic teaching, role-playing, and other methods. After the main treatment material has been covered the therapists ask for *feedback*, which allows the therapists to adjust their approach and methods for working with the client. Therapists also are encouraged to give feedback to their clients as a way to (a) build the therapeutic relationship, (b) give positive encouragement, and (c) address particularly distorted cognitions (Wright, Basco, & Thase, 2006). Finally, *homework* is again assigned to the clients, which allows the clients to test their hypothesis regarding their perceptions of real-life events and whether these perceptions should be modified based on what was practiced in session. These homework assignments are a collaborative endeavor, where the therapist and the client discuss what assignment would be most helpful to work on until the next session.

Finally, although not necessarily a focus of every session, a final part of the CBT framework is *generalization* and *relapse prevention*. Generalization is often used throughout the course of therapy to help the clients apply their newfound skills to a variety of situations, not just specific issues they initially brought with them into therapy. For example, children who learn to modify their cognitions and behaviors when receiving a failing grade in one academic subject would learn to do the same with other subjects. Relapse prevention typically occurs toward the end of therapy and focuses on identifying posttreatment impediments. Once these impediments are labeled, the therapist and the client brainstorm ways in which they can be addressed (e.g., role-play) to practice alternative ways of responding.

COMMON COGNITIVE-BEHAVIOR THERAPY TECHNIQUES

Therapists will often rely on a number of specific techniques that can be used alone or in conjunction with others. The following is a review of some of the most commonly reported techniques.

Socratic Questioning

Socratic questioning is perhaps the most widely known and employed CBT technique. In this form of questioning, the therapist feigns ignorance to elicit the client's complete knowledge on a particular topic. Incomplete or inaccurate ideas can then be corrected during follow-up questioning, which can help correct a client's misinterpretations and can lead to more realistic thought processes.

Problem Solving

Clients often have numerous difficulties that may or may not be related to the initial referral problem. During problem solving, which is usually done in the first session, the client and therapist create a problem list that is described in clear, concrete, and goal-oriented language. During subsequent sessions, the therapist asks the client whether any new problems have developed that should be added to the list. Initially, the therapist designs problem-solving strategies for the clients, but over time the clients are encouraged and expected to assume a more active role and generate their own strategies. Didactic instruction of components that comprise adaptive problem-solving skills is often first necessary for many clients, particularly young children. For other clients who have good problem-solving skills but are hesitant to apply the strategies, the therapist and client focus on the client's perceptions that hinder the strategy from being implemented. Various techniques such as Socratic questioning, using a problem-solving worksheet, and role-playing are often employed in this case.

Cognitive Restructuring

Cognitive restructuring is an umbrella term for a variety of cognitive-based techniques designed to reduce, modify, or replace a client's cognitive distortions. Some techniques have the therapist directly challenging and refuting the client's distortion, whereas others involve a more collaborative relationship by having both the therapist and client examine the logic of the client's perception and systematically testing its veracity. For example, the therapist and the client may examine via a problem-solving worksheet the "evidence for and evidence against" perceptions held by the client. As another example, clients are asked to complete a sheet containing separate columns specific to an event, their thoughts regarding the event, and their corresponding feelings. The sheet is completed outside of the session and discussed later with the therapist, which helps the client understand the causal connections between the three columns. In time, and once the client understands these relationships, an additional fourth column is added to the sheet, and the client is instructed to provide an alternative interpretation of an experienced event, or one that is different than how they would normally interpret the event.

Self-Monitoring and Self-Regulation

Self-monitoring requires the clients to keep a log that records their cognitions, affect, and behaviors in response to online events. In addition, the clients briefly describe situational variables that precede these reactions. As the clients understand the context around their distorted thinking, they are taught an adaptive response to use in response to their reactions. For example, when a student with test anxiety becomes aware of their

distress (i.e., they become aware of physiological markers as well as their corresponding cognitive distortions), the act of recording this distress serves as a cue to initiate adaptive coping strategies (e.g., relaxation exercises, deep breathing). Another technique is self-regulation, where clients compare the number of recorded times that they reverted back to their maladaptive cognitions and behaviors against the number of times that they used adaptive cognitive and behavior strategies. Should the outcome exceed a predetermined goal or standard, the client is self-reinforced and/or reinforced by the therapist and others.

Affective Education or Mindfulness

In affective education or mindfulness training, clients are taught to become cognizant of their emotions, to see their emotions as cues to their cognitive distortions and maladaptive behaviors, and to realize that their emotions do not always need to be acted on. Many clients (including children) have a difficult time identifying and labeling their emotions, knowing how to appropriately respond to certain emotions, or realizing that their emotions directly stem from their cognitions. In affective education, clients are taught to identify and label their emotions and to recognize the breadth of emotional responses (rather than simple dyadic labels such as happy/sad). Second, clients learn that extreme emotional responses can interfere with logical thinking and that they have the option of responding to a situation before their emotions become too extreme. Role-playing or modeling exercises are often practiced in session, which helps clients learn how to best cope with their emotions in real life and in frequently experienced situations. In mindfulness training, the client understands that emotions do not always require a behavioral or cognitive reaction and sometimes it is permissible to accept the feeling as part of the human condition without doing anything. As part of mindfulness training, some therapists will enlist the use of meditation exercises or tapes that focus on either clearing the mind or on blocking out external stimuli, which allows clients to become more aware of their internal thoughts and feelings.

Relaxation Training

Many clients report a significant reduction in their internal distress by learning and practicing a variety of exercises, ranging from deep and slow diaphragmatic breathing combined with repeating a simple word (e.g., "relax"), to more complex and sequential muscle relaxation procedures. Some clients who have experienced trauma or who are highly anxious report that relaxation training actually heightens their level of anxiety, thus the therapist should consider introducing these techniques as an experiment that *may* cause relaxation or *may* lead to anxious thoughts. In the latter case, the client learns and practices other techniques described in this section to reduce their anxiety.

Modeling and Role-Playing

Modeling and role-playing are two techniques commonly used with clients, especially with children and their parents. In modeling, the therapist displays an appropriate behavior for the child to replicate or, in some cases, works with the parents to ensure that they are modeling positive behaviors for their child to learn and imitate. In role-playing, the child and the therapist actually enact a situation and the child practices a newly learned and perhaps more appropriate behavior. For example, if children are having difficulties being assertive in class, the therapist might role-play the teacher and ask the children to practice raising their hand and responding when called on. Role-playing can help to decrease the emotion attached to the situation and allow children to feel more secure in trying the new behavior outside of the session.

Exposure Therapy or Imagery

Exposure therapy (ET) is commonly used when the client has developed a fear of some stimuli; a reaction commonly found in individuals with specific phobias, obsessive compulsive disorder, or posttraumatic stress disorder (PTSD). Prior to ET, the clients rate their initial or "baseline" level of distress using the Subjective Units of Distress Scale (SUDS). Through imagery or in vivo exercises, the client is gradually exposed to anxiety-evoking stimuli for longer periods of time. Imaginal exposure typically takes place in the therapist's office with the clients imagining they are interacting with the stimuli. For instance, the clients may simply imagine that they are sitting in a classroom if they have a fear of school. Often used in conjunction with imaginal exposure, in vivo exposure requires the client to be in the presence of the feared stimuli, with the level of exposure gradually increasing. For example, in the case of school phobia, the client may first sit in a car in front of the school, followed by sitting in the car and driving to school, followed by having the child sit in an empty classroom for 30 minutes, and finally by having the client sit in a full classroom. During each condition, the clients are taught to monitor their SUDS rating and to stay in the exposure until their rating drops to some predetermined level. In vivo exposure teaches the clients that the stimuli will not hurt them and that they can become safely accustomed to interacting with the stimuli.

APPLICATIONS WITH CHILDREN

Identical to adults, the aims of CBT for children are to help them identify their most problematic cognitive distortions, test these distortions in session under the guidance of a therapist and outside the session through homework assignments, and develop more rational thinking. Nevertheless, unlike adults, developmental factors must be considered when implementing CBT, especially among young (i.e., preadolescent) children.

Three factors are specifically mentioned. First, Piagetian theory asserts that the capacity to form abstract and self-reflective thoughts is only consistently attained at later stages of development. Although it is now generally felt that Piaget may have underestimated the ability of younger children to process abstract material (Meadows, 1993; Rochat, 1995), there is enough empirical evidence to indicate that young children (i.e., under age 8) maintain only rudimentary higher order reasoning skills (see Grave & Blissett, 2004; Miller, 2009). Given that CBT requires individuals to be aware of their cognitive distortions and that they must have the capacity to understand the relationship between cognitions, affect, and behaviors, these higher order cognitive processes may be beyond the reasoning abilities of most young children. For example, in Beck's cognitive therapy for depression (A. T. Beck, 1967), it is assumed that individuals have the capability to distinguish rational from irrational thoughts once they are identified in session. Nevertheless, young children may not understand this distinction, and distorted thinking is in fact both a hallmark of early childhood and a product of normal development (Shirk, 1998). Thus, it is important that CBT practitioners understand characteristics that typify normal and abnormal development and should be aware of the limitations of applying CBT with young children.

Second, care must be taken to avoid the "developmental uniformity myth" (Kendall & Choudhury, 2003), where children at different ages exhibiting the same behavior problems are assumed to be alike. Cognitive, social, and affective variables all contribute to children's self-perceptions and their views of others, and the complexity of these relationships increase with age. Although CBT may be effective for one young child, developmental growth in (a) language development, (b) memory skills, and (c) behavioral skills such as self-regulation varies for each child and thus precludes assuming that CBT will work with every child in an age group. Selection of specific CBT techniques (when appropriate) must incorporate each child's unique strengths and limitations.

Finally, the therapist should be aware of the various ways in which youth often come to therapy, and how these reasons may differ as a function of the child's age. Although adults primarily self-refer to treatment, youth (particularly young children) are most often referred to therapy by adults (e.g., parent, guardians, teachers). There may be instances when the child's behaviors are symptomatic of larger problems in the family that would not necessarily be ameliorated through individual CBT alone. The level and type of involvement of family members in a child's treatment can have a dramatic impact on the success of the therapy (Field & Duchoslav, 2009; Kazdin, Holland, & Crowley, 1997), and for this reason there has been increased emphasis on including parents or guardians in CBT treatment models for children.

Although CBT has been criticized for its failure to recognize important developmental differences that may mediate the success of CBT (Stallard, 2009), research indicates that modified approaches for young children, including using (a) less complex, verbally based

techniques, (b) parents to reinforce concepts practiced in sessions, (c) play therapy to communicate concepts, and (d) more behaviorally active learning techniques can lead to improvements in both cognitive reframing and problematic behaviors (Minde, Roy, Bezonsky, & Hashemi, 2010). Some of the most common child difficulties that have been addressed through CBT are described.

Depression

Most CBT treatments are based on the assumption that depression is caused and maintained through faulty cognitions and maladaptive coping behaviors. Thus, modifications of the child's cognitions, affect, and behaviors are targeted simultaneously. General techniques among young children include first teaching the children to understand the distinction between their thoughts and feelings through didactic teaching, role-playing, and mutual storytelling, all of which are then practiced during weekly homework assignments (typically by having the children complete depression logs). Once the children understand this distinction, the children and the therapist discuss occasions and activities that elicit positive and negative moods, and the therapist helps the children understand how their thoughts may have influenced their behaviors. Concurrent behavioral techniques that are often employed include having the child continue to engage in pleasant activities, and teaching social problem, assertion, or social interaction skills when the child is engaged in unpleasant (or depression-inducing) activities. In addition, cognitive restructuring activities are practiced both during the session and throughout the week. Such activities include having the children set appropriate goals (i.e., goals that can be readily attained), identify their distorted cognitions (which typically focus on the cognitive triad), and learn to replace these distortions with more adaptive and constructive thought processes. Finally, affect management skills include relaxation during times of stress and other impulse control techniques.

Some single-case and multigroup studies illustrate how various CBT techniques can be applied to children. For example, Asarnow and Carlson (1988) applied CBT with a 10-year-old female living in an inpatient setting for severe depression. The first week of treatment involved having the child rate her mood on a 1 to 5 scale (ranging from happy to sad). The child and therapist then reviewed when she was feeling happiest and factors that contributed to this positive affect. (Gradually, the rating form was expanded to include columns where the child could rate her thoughts, feelings, and behaviors during all activities.) Concurrent to this, the therapist worked with the child to examine links between her mood states, cognitions, and activities. As the sessions progressed, continued identification of dysfunctional cognitions (both in session and throughout the week) and replacement of maladaptive coping strategies with adaptive problem-solving skills were taught and practiced. Role-playing exercises and homework assignments were standard techniques. Pharmacotherapy was also used as an intervention during admission,

but was discontinued at discharge. Results found significant short-term and long-term improvements in the child's mood with no relapse. Further, Stark, Reynolds, and Kaslow (1987) evaluated two separate CBT approaches with 39 children diagnosed with moderate depression. The first approach consisted of the following strategies across a 5-week time span:

Sessions 1 to 4: Children were taught to self-monitor their thoughts and mood when participating in pleasant activities (through the use of log sheets).
Session 5: Children were taught to monitor the long-term rather than the immediate consequences of their actions.
Sessions 6 to 7: Children were taught to replace maladaptive attributions with more adaptive attributions.
Sessions 8 to 9: Children were taught to replace unrealistic expectations with more realistic standards when evaluating their performance.
Sessions 10 to 12: Children were taught to increase their level of self-reinforcement (using both overt and covert methods) and to reduce the amount of self-punishment when evaluating their performance. The final portion of Session 12 was a review of the skills that were taught.

The second approach included these same activities but also included problem solving in social situations and a discussion of the relationship between their maladaptive thoughts and behaviors and how these may negatively affect their social relations. The results found that both treatment conditions yielded significant improvement on depression scores, in comparison to a wait-list control group. Follow-up studies that combined both methods into a multicomponent CBT intervention found that in comparison to a nonspecific psychotherapy control group, children in the CBT group reported significantly fewer depressive symptoms and fewer distorted cognitions.

Anxiety Disorders

The more frequently cited CBT intervention for anxiety disorders is based on the work of Phillip Kendall's Coping Cat program (e.g., Kendall, 1990), who incorporated five components into a multicomponent program:

1. Psychoeducation (having the child understand information about anxiety and the feared stimuli).
2. Somatic management skills training (targeting arousal and other physiological responses).
3. Cognitive restructuring (identifying cognitive distortions and replacing them with more adaptive coping thoughts).

4. Exposure methods (controlled exposure to fearful stimulus).
5. Relapse prevention plans (generalizing the treatment gains over time; Albano, Chorpita, & Kendall, 1996).

The treatment consists of approximately 14 to 18 sessions over a 12- to 16-week period, with each session lasting approximately 1 hour. A review of the program can be found in Hudson and Kendall (2002) and Kendall (1994), but in brief, the treatment is based on five specific principles, whereby children:

1. Learn to recognize anxious feelings and physiological reactions related to anxiety.
2. Identify (with the help of the therapist) their unrealistic expectations and distorted cognitions in anxiety-provoking situations.
3. Develop a plan to help them cope with anxiety-producing situations.
4. Are gradually exposed to the anxiety-provoking stimuli or situations.
5. Evaluate their performance by using self-reinforcement (rather than self-punishment or negative self-talk) strategies.

Specific CBT techniques include modeling, imaginal and in vivo exposure, role-playing, relaxation training, and contingent reinforcement. Homework tasks are also assigned and specific techniques are practiced to avoid relapse prevention. In addition to individual therapy, parents are also often involved through direct (i.e., participation in the treatment plan) or indirect (i.e., consultation) methods. The first half of the program is designed to teach the child the new skills, while the remaining half focuses on having the child practice the skills both in session and in vivo. Empirical studies of the Coping Cat program consistently demonstrate its effectiveness in alleviating short- and long-term anxiety symptoms (e.g., Barrett, Duffy, Dadds, & Rapee, 2001; Kendall, 1994).

Other CBT therapies aside from the Coping Cat program have also demonstrated their effectiveness in lessening anxiety among very young children. For example, Minde et al. (2010) reported that CBT can successfully manage anxiety symptoms among children as young as 3 years of age by involving parenting in the curriculum. Specifically, among a sample of 37 young children (between the ages of 3 and 8) referred to a university clinic specializing in anxiety problems, participants spent 40 minutes learning how to reframe their worries, how to develop more appropriate coping skills by "talking back" to their negative thoughts, and choose a specific goal to shoot for during the week. Parents then attended the final portion of the session with their child (20 minutes) to receive feedback on the session, to further learn about anxiety disorders, and to discuss how they can help their child successfully attain their weekly goal. Results yielded significant reductions in anxiety symptoms, based on parent- and teacher-reports, as well as better

adaptive functioning (per clinician report). Likewise, Monga, Young, and Owens (2009) demonstrated that CBT can be successfully applied in group-format to alleviate anxiety symptoms among young children. Among 32 children (between the ages of 5 and 7) diagnosed with anxiety disorder, the authors developed a manualized treatment protocol that had children recognize various feeling states, learn relaxation strategies when placed in anxiety-provoking situations, and developing alternative patterns of thoughts ("brave thoughts") when they become aware of their anxiety. In addition, parents participated in concurrent sessions where they received information about anxiety and learned the strategies that were being taught to their child. Results of the group intervention found that after 12 weeks, more than 40% of the participants no longer met criteria for any anxiety disorder, and 72% had at least one anxiety disorder resolved with treatment.

Obsessive-Compulsive Disorder

Most CBT interventions involve teaching children to recognize and relabel their intrusive and distressing thoughts, and to reexamine the likelihood that the fearful consequence will actually occur if the obsession is not acted on. Techniques for young children include providing information regarding the disorder, establishing a behavioral rewards system for treatment compliance (including direct family involvement), and teaching appropriate metaphors to facilitate cognitive restructuring (Piacentini, 1999). In some forms of CBT—especially in cases that do not involve moral guilt or pathological doubt, exposure to cues that elicit the obsessive thought is often used, which also requires having the child wait for at least an hour before demonstrating the typical ritualistic behavior (Rappaport & Inoff-Germain, 2000). Although studies to investigate the efficacy of CBT for children with OCD have been few, there is enough evidence to suggest that the intervention yields significant reduction in obsessive and compulsive symptoms, with treatment gains noted up to 3 months post-treatment (Williams, Salkovskis, Forrester, Turner, White, & Allsopp, 2010).

Piacentini and Langley (2004) reported a case-study of a 12-year-old Asian-American male who exhibited obsessions on themes surrounding contamination of himself and others. Ritual behaviors surrounding these thoughts included excessive hand-washing and constant reassurance from his parents. Symptoms were first noted at age 8 and began to interfere with daily and social functioning at age 10. The course of treatment included the following components:

Psychoeducation

The child and his parents received information on OCD, which served to reduce the feelings of stigma, anger, and blame surrounding the disorder. The information also helped the child understand that he was not the only person to have the problem. Presentation of OCD as a neurobehavioral disorder helped reduce family conflict, and

a rationale for the use of CBT was provided to prepare the family and the child for the selected treatment techniques.

Cognitive Restructuring

The child was taught to recognize and relabel his obsessive thoughts and feelings in a more realistic fashion. He also learned to test his fear hypotheses using a "fear thermometer," a simple measure that was used to estimate the probability that a feared outcome would actually occur. Constructive coping statements were also learned during the session and practiced throughout the week (via established homework assignments).

Exposure Plus Response Prevention

The therapist encouraged the child to have contact with the feared stimulus and to resist conducting ritual behaviors over the course of the exposure period. Fear thermometer ratings were assessed every 30 to 60 seconds at the trial outset and then less frequently as the duration of the exposure increased. The ratings were graphed so that the child could see his progress throughout the course of treatment.

Addressing Obsessions

The child's obsessions were also addressed by having him (a) write his thoughts or images on a log, (b) describe these thoughts or images aloud to the therapist, (c) listen as the therapist read his thoughts back to the child, and eventually (d) create silly songs or other humorous creations out of his thoughts. These activities served to normalize the obsessions, thereby reducing their discomfort and frequency of occurrence.

Family Intervention

In addition to psychoeducation, the family was taught to attribute the OCD symptoms to the disorder itself rather than to the child. The family was also instructed how to disengage from the child's OCD behaviors, which helped develop more normal patterns of family interaction.

The results found that after 12 sessions, a significant decrease in OCD symptoms was noted (as evidenced by self, family, and peer reports). The child reported that he was able to function in social activities without worrying about his obsessions, and significant gains in adaptive coping skills were noted.

Recent studies also have applied CBT to even younger children diagnosed with OCD. For example, Choate-Summers et al. (2008) reported the results of a family-based protocol among 42 children between the ages of 5 and 8 who were referred for treatment at university-based anxiety disorders clinics. Highlights of the 12-session, weekly intervention included (a) providing the children and their parents with "tools" to understand and identify OCD symptoms, (b) psychoeducation to parents prior to the child entering

treatment, (c) exposure training within the context of developmental play, and (d) formal parent training to help parents learn tools to help their child cope with their OCD symptoms. Results of the intervention were positive, with 62% of treatment completers achieving clinical remission of symptoms (in comparison to 20% of children placed in an active control condition).

Social Phobia

Although once thought to be a temporary condition that children could outgrow or due to a personality characteristic (i.e., being shy), social phobia (SP) has drawn clinical interest given that its prevalence is approximately 6% to 8% of youth (Chavira, Stein, Bailey, & Stein, 2005; Mancini, Van Ameringen, & Bennett, 2005). Fears of public speaking, reading, writing, or eating are common, which can induce physical symptoms of anxiety (e.g., blushing, shaking, stomachaches), and specific symptoms may extend along developmental lines. For example, young children with SP may demonstrate symptoms such as throwing a temper tantrum, crying, or shrinking from unfamiliar people, while older youth may develop avoidance from settings or situations, or "playing the class clown" to avoid their anxiety (DeWit, Ogborne, & Offord, 1999). Social phobia often precedes other mood disorders such as generalized anxiety disorder and depression (Rapee & Spence, 2004) and thus improving the symptoms related to SP may help improve the symptoms of other shared conditions.

Traditional treatment of SP involves the use of behavioral techniques (e.g., guided imagery and in vivo exposure to the fear stimulus), systematic desensitization, and contingency management. However, more recent conceptualizations take a cognitive-behavior perspective, where children process socially relevant information in an excessively negative and feared manner. Exposure to the feared stimulus serves to maintain the phobia. Hirsch and Clark (2004), for example, outline several explanations for how individuals view social interactions as threatening, including (a) making excessively negative predictions about future events, (b) interpreting ongoing social events negatively, (c) selectively retrieving negative information regarding past social events, (d) having distorted negative images regarding their own social competency, (e) showing reduced processing of social cues, and (f) tending to negatively focus on and interpret information in social cues. Cognitive-behavioral therapy techniques thus focus on having individuals review the likelihood that a negative event would occur in the future and reappraise their memories of previous social situations and teaching more adaptive and reasonable appraisals when in current social situations. Methods used to teach these techniques include psychoeducation (i.e., teaching children about their phobia, and exploring the cognitive distortions underlying the phobia), social skills training, cognitive restructuring, relaxation training, and for many youth, gradual exposure. Among younger children, some of these techniques may be modified.

For example, Miller and Feeny (2003) modified the use of CBT for a 5-year-old female with SP by also including novel exposure techniques and including parents in the treatment design to promote generalization outside of the therapy session.

Most of the studies to demonstrate the efficacy of CBT for SP among children are based on case studies, with results reporting remission of most problematic symptoms for up to 1 year. Spence, Donovan, and Brechman-Toussaint (2000) investigated the efficacy of an integrated CBT procedure for a group of children (ages 7 to 11) and adolescents (ages 12 to 14) who were diagnosed with SP. Each session lasted for 1 hour, followed by a 30-minute period of social games where the participants practiced newly learned skills under the guidance of the therapist. Specific components that were taught included social skills, relaxation techniques, social problem solving, positive self-instruction, graded exposure, and (among older youth) cognitive challenging. Corresponding skills for the components included:

Social Skills Training

Basic skills that were taught included maintaining eye contact, positive affect, and an even tone and volume of voice. These skills were integrated in more complex social behavior skills such as verbal attending and conversation skills. Following these skills, specific friendship skills were taught and practiced, such as sharing, inviting others to play, and giving compliments.

Problem-Solving Skills

Children were taught to use the "Social Detective Technique" when coping with challenging situations (e.g., being bullied or teased) or when the children needed to be more assertive in social situations. "Detect" involved having the child stop and assess exactly what the problem was. "Investigate" involved having the child relax, brainstorm alternative solutions and potential outcomes, and choose the best solution of the list. Further, older children were taught to both test the evidence surrounding their thought distortions and explore alternative and more adaptive thoughts. The authors noted that young children had a difficult time challenging their cognitions or understanding how to test the evidence for and against their perceptions. Thus, young children learned how to use positive self-talk ("I can do this"; "I can use my social skills") in stressful situations. Finally, "Solve" consisted of the child devising a strategy to carry out the solution, evaluating the solution, and using self-praise.

Relaxation Techniques

Participants spent 10 minutes at the end of each session practicing a range of imagery and deep-muscle exercises.

Weekly homework assignments were given, with the assignments focusing on a particular skill but gradually increasing in difficulty as the child mastered the skill. For example, the children during the early portions of treatment would practice basic social skills such as making eye contact, and progress up to and through inviting a peer to come over and play at their house. Booster sessions were also conducted at 3- and 6-month posttreatment to maintain and reinforce previously acquired material. The results found that in comparison to a wait-list control group, significant improvement in SP symptoms were noted in children who were given the integrated CBT package, and treatment gains were maintained at the 12-month follow-up.

Melfsin et al. (2011) conducted one of the few randomized, controlled studies demonstrating the efficacy of CBT among a sample of young German children diagnosed with SP. The treatment protocol consisted of twenty 50-minute individual sessions, as well as four parent sessions. Content included psychoeducation, cognitive restructuring through picture stories and games, testing of safety and avoidance behaviors through role-plays and videotaping (with feedback), and (for parents) information on social anxiety and ways to help them deal with their child's fears. Results found that at posttest, significantly more children were free of SP than children placed in the wait-list group at posttest.

School phobia (or refusal) is considered a special case of social phobia (Morris & Ale, 2011). The disorder is characterized as a cluster of symptoms including chronic absenteeism, initially going to school but leaving during the day, and concomitant psychological distress and somatic complaints related to being in the school environment (Kearney & Bensaheb, 2006). Studies to investigate the efficacy of CBT on school refusal among children have been few, although what has been published has yielded positive results. For example, Last, Hansen, and Franco (1998) applied in vivo exposure and coping self-statement training for a group of children and adolescents who were referred for school phobia. During the first session, the children constructed a hierarchy consisting of 10 school-related items that the children feared or avoided. During the second session and all sessions thereafter, the children were taught to identify their maladaptive thoughts and anticipate and/or confront an anxiety-producing situation. Homework assignments were also given, which consisted of having the children practice a particular item on the hierarchy throughout the week until the next session. These assignments increased in difficulty as the treatment progressed. As the amount of in vivo exposure increased, the child (and parent) reevaluated the hierarchy. Coping self-statements were also practiced during the child's weekly homework assignment, which served to reduce anxiety. The results found some support for the use of this form of psychotherapy for children, as short-term and long-term (i.e., 4-week follow-up) improvements were noted across both subjective (i.e., perceptions of improvement) and objective (i.e., school attendance) indicators. Nevertheless, there were no marked differences between

children in the CBT group versus children who were placed in a psychoeducational group (i.e., children were educated about their condition but no strategies were provided to help them confront the feared situations), suggesting that nonspecific effects (e.g., quality of child-therapist relationship) were involved. More recent studies that have combined both approaches—treatments that incorporate psychoeducation strategies, relaxation training, cognitive restructuring, and gradual exposure into a manualized treatment package—yield significant improvements in school phobic behaviors in comparison to wait-list controls (see King & Bernstein, 2001).

Trauma

Posttraumatic stress disorder is commonly associated with other disorders including depression, anxiety, and anger, thus treatments usually include interventions that can address these related symptoms as well. In recent years, there have been significant gains in the treatment of children who have been exposed to traumatic events primarily by adapting adult treatments for children and youth. Trauma treatments typically involve the nonoffending caregivers and other family members, if at all possible, to avoid the implication that the child is at fault and to ensure positive changes for the family.

Cognitive-behavioral therapy interventions are the most commonly researched and supported treatment models for childhood trauma (see Chard, Gilman, Holleb, & Teeters, 2012). Cognitive-behavioral therapy treatments for children typically include one or more of the following: (a) exposure to the traumatic material, (b) cognitive reprocessing and reframing, (c) stress management, and (d) parent treatment. Exposure techniques for children can vary from talking about the traumatic event, drawing pictures about the trauma, writing about the trauma events, or recounting the events into a tape recorder. Although exposure to the traumatic memory is the therapeutic norm, therapists should note that not all children need to process the trauma and instead may find that going over the trauma is either boring or so anxiety producing that it is counter to therapeutic gain. Cognitive-behavioral therapy techniques usually adopt those used in *Cognitive Processing Therapy* (Resick & Schnicke, 1992). The most commonly used stress-reduction interventions involve diaphragmatic breathing, muscle relaxation, and in some cases "thought stopping," where the child is given a replacement thought to say every time a distressing thought occurs.

A growing body of research studies supports the use of CBT interventions with preschool children ranging from the ages of 2 to 18 (Smith et al., 2007). For example, in a recent randomized clinical trial, Scheeringa, Weems, Cohen, Amaya-Jackson, and Guthrie (2011) examined the effectiveness of trauma-focused CBT (TF-CBT) among 42 children between the ages of 3 and 6 who experienced a life-threatening traumatic event and were formally diagnosed with PTSD. As a treatment, TF-CBT is a highly structured, manualized protocol that includes (a) psychoeducation about PTSD,

(b) recognition of feelings, (c) trainings in coping skills, (d) graduated exposures to trauma-related reminders using age-appropriate materials (e.g., drawings) as well as using guided imagery and in vivo exposure, and (e) safety planning. Developmental modifications were made given the young age of the children, and parents either were in the same room as their child during treatment or observed the session in real-time (via television) to learn the material. Results found that in comparison to those placed on a wait-list control, children in the TF-CBT group exhibited significantly fewer PTSD symptoms over the 12 sessions of the intervention. The effect size of these group differences was in the large range. Similar findings have also been reported with respect to manualized cognitive therapies as applied in group format across multiple environments, including schools (e.g., Ngo et al., 2008; Stein et al., 2003).

APPLICATIONS WITH ADOLESCENTS

Many of the CBT interventions described earlier have also been used for adolescents experiencing the same conditions. In some respects, application of CBT to adolescents may be relatively easier than to young children, given the former groups' developed abstract thinking abilities, social problem solving, and level of insight that would allow for a deeper exploration of cognitive distortions, dysfunctional attitudes and beliefs, and maladaptive behaviors. Nevertheless, developmental characteristics that are unique among this age group need to be considered by the therapist. For example, the late adolescent period signifies the final stages of preparation for life beyond graduation and, for most adolescents, the last ties to dependence on their parents. This awareness can lead to the adolescent beginning to examine their identity and place in the world and questions regarding their future become more salient and less ambiguous. Related to these self-appraisals is the adolescent's view of self in relation with others. Appraisals of perceived competence in handling life challenges are based on a complex system of interactions of parents, peers, romantic partners, teachers, and others at a level that is not usually observed among young children. This reciprocal interaction between internal thoughts and external comparisons can create a litany of potential cognitive distortions, many of which can interfere with daily functioning. Clinicians should be aware of these multiple sources when applying CBT to adolescents.

Other points to consider are due to the disorders themselves, or to factors that would interfere with the treatment process. For example, Kennard, Ginsburg, and Feeny (2005) discussed specific challenges faced by CBT therapists as they investigated the effectiveness of a treatment for adolescents diagnosed with major depressive disorder. These challenges included (a) the high comorbidity of depression with other disorders, which could attenuate the effectiveness of the treatment; (b) the severity of some of the depressive symptomatology (e.g., sense of hopelessness); (c) the severity of self-harm and suicide

ideation; (d) interpersonal factors; and (e) treatment noncompliance. Perhaps with the exception of suicide ideation or self-harm, most of the challenges could be generalized to any adolescent disorder.

Depression and Anxiety

Cognitive-behavioral treatments for adolescent depression and anxiety often mimic techniques that have been found useful with adults, although modified to some extent. Reviews by Webb, Auerbach, and DeRubeis (2012), and Reinecke and Jacobs (2010) provide an overview of specific components of CBT with adolescent depression and anxiety, respectively. For depression, essential components include psychoeducation (i.e., teaching the adolescents and their family about the disorder, including how depression is conceptualized from the standpoint of CBT), replacing self-defeating thoughts with more constructive and positive thinking, increasing participation in pleasant activities, teaching adaptive and constructive social and communication skills, teaching conflict resolution skills, and teaching self-monitoring and goal-setting skills. For anxiety, essential components include psychoeducation (teaching the child and family how and why excessive levels of anxiety are leaned and maintained, and the rationale for various treatment techniques), somatic management techniques (e.g., deep breathing, relaxation training), cognitive restructuring (e.g., identifying unhelpful, anxiety-provoking thoughts, challenging these thoughts, and replacing them with more proactive and adaptive thinking), problem solving (e.g., asking the adolescent to test a variety of methods for coping with anxiety-inducing situations), and exposure (e.g., systematic and gradual exposure).

Implementing CBT treatments via electronic means is an emergent area in adolescent depression research. Although in its nascent stage, there is enough research to indicate that computerized CBT can effectively reduce depression/anxiety symptoms (see Richardson, Stallard, & Velleman, 2010, for a recent review). For example, Stallard, Richardson, Velleman, & Attwood (2011) conducted a randomized controlled trial consisting of 20 adolescents (ages 11 to 16) presenting with a primary problem of anxiety or mild/moderate depression. Adolescents placed in the immediate treatment group were administered a six-session "think, feeling, do" protocol, which itself was based on the *Think Good—Feel Good* workbook designed for younger youth (Stallard, 2004). Each program was 45 minutes in length and covered topics such as psychoeducation, emotion recognition/management, thinking positively, and problem-solving. The protocol is interactive, with multimedia (e.g., sounds, photos, music, and video clips) to guide the user through the sessions. Responses are saved so that previous work can be reviewed, and homework assignments are given at the end of each session. Results found that in comparison to the control group, significant posttreatment reductions in anxiety/depression symptoms were reported by adolescents in the treatment group. In addition, adolescents

receiving the intervention reported high levels of satisfaction with the computerized protocol, and that the protocol helped them understand their problems and to find new ways to cope with them.

Aggression

Aggression and its many related constructs (e.g., anger, hostility, impulsivity) are viewed as a core symptom of various disruptive disorders, including oppositional defiant disorder and conduct disorder, making it one of the most substantial social problems in today's society. Various studies have investigated environmental and biological factors that contribute to aggression (see Card, Stucky, Sawalani, & Little, 2008; Rappaport & Thomas, 2004; Vaughn & Santos, 2007, for reviews). In addition, studies investigating aggression over the past three decades have found that cognitions play a key role in determining whether (and when) aggression occurs (Arsenio, Adams, & Gold, 2009). The social-cognitive information approach has become one of the main models to explain aggression in children and adolescents. Various reviews have synthesized the literature regarding various social-cognitive information models and aggression in youth (e.g., Dodge, 1980; Dodge & Crick, 1990; Huesmann, Dubow, & Boxer, 2011; Lochman, Powell, Whidby, & FitzGerald, 2012; Pakaslahti, 2000), the essence of which is briefly reviewed below.

In general, youth regulate and monitor their behavior in social situations based on a series of sequential steps. Youth are first oriented toward a potentially problematic social situation based on their past experiences, and they attend to situational (and internal) cues based on these experiences. For aggressive youth, more attention is paid to aggressive cues and less attention is given to gathering additional facts related to the situation than less aggressive youth. Causality is then inferred based on these cues (e.g., why the event occurred and what the intent of the other youth was). For aggressive youth, inferences are often made that the intent of the other youth was hostile and was made with harm in mind. Given this interpretation, the youth then formulates a behavioral goal for the situation. Aggressive youth often choose hostile, revenge-seeking goals and less often choose peer affiliative goals (i.e., goals that facilitate mutual cooperation and peacekeeping). The youth then cognitively selects a strategy (based on similar strategies that worked in the past) that would most likely solve the social problem. In comparison to nonaggressive youth, aggressive youth often choose strategies that are limited in scope (i.e., few compromise or peer-affiliation strategies) and, given their previous success using similar strategies, that involve aggressive or impulsive themes. Before ultimately selecting a strategy, the proposed response is compared with the youths' internal standards (including an appraisal of their values and normative beliefs) and against any potential consequences of using that response. When making these comparisons, aggressive youth evaluate aggressive strategies more favorably than their nonaggressive peers,

tend to perceive aggressive strategies as more likely to yield the desired outcome, and do not anticipate any consequences for their strategy. Finally, when all steps are considered, the youth enacts the most valenced strategy. In addition to their descriptive value, one of the advantages of social-cognitive processing models is their explanation of why aggression is maintained. For aggressive youth, an ongoing feedback loop is established, where a predisposed tendency to attend to aggressive social cues (i.e., without considering all information) leads to a subjective and hostile interpretation of the event based on these misinterpreted cues, ultimately leading to the youth selecting behavior that is most consistent with the interpretation.

The goal of CBT is thus to have the youth reexamine their original selection of environmental or internal cues, to seek more facts about the situation before formulating and selecting a behavior, to select less hostile and more adaptive problem-solving solutions, and to anticipate the consequences of their actions. Interventions usually involve role-playing, practicing of social skills and cognitive reinterpretation in session, homework assignments, and involvement of parents.

Although studies to investigate the efficacy of CBT in reducing aggression have been limited, published papers have revealed that both clinic- and school-based interventions can reduce aggression over the long term. As one early example, Guerra and Slaby (1990) applied a form of CBT to 120 male and female adolescents incarcerated for aggression offenses. The youth were randomly assigned and placed into a CBT group, an attention-control (where only basic skills were taught) group, and a no-treatment group. All groups met over a 12-week period for 1 hour per week in a group format. Skills that were taught and practiced in the CBT group included having all youth (a) attend and react to nonhostile (rather than hostile) cues when reacting to a social problem and formulating goals, (b) seek additional information when interpreting a social problem, (c) generate a variety of responses and strategies based on this new interpretation, and (d) prioritize legal, goal-directed, and nonviolent outcomes for each strategy. Youth were also challenged to review their beliefs that aggression was an appropriate, legitimate, and effective strategy by assessing what has happened to themselves and others by using this strategy. Finally, self-control strategies were provided to youth in the CBT group. All sessions followed an eight-step sequential problem-solving model that consisted of having the youth ascertain the following items in response to a potential social problem situation:

1. Is there actually a problem?
2. Stop and think.
3. Why is there a conflict?
4. What do I want?
5. Think of solutions.

6. Look at consequences.
7. Choose what to do and do it.
8. Evaluate the results.

The results found that in comparison to the attention-control and no-treatment group, youth in the CBT group self-reported and were reported by their supervisors as having greater social problem-solving skills, reducing their endorsement of aggression strategies as viable and appropriate, and reducing their aggressive and impulsive behaviors.

More recent therapies continue to adapt Kendall's (1993) cognitive-behavioral procedures for youth (modeling, building adaptive cognitive coping skills, using rewards to modify behavior, researching appropriate behavior, affective education, and training tasks), with the focus on reducing aggressive incidents. Results of several meta-analyses (e.g., Ozabaci, 2011; Sukhodolsky, Kassinove, & Gorman, 2004) find that programs that utilize these techniques can effectively reduce adolescent aggression, with reported effect sizes typically in the medium range.

FAMILY INTERVENTIONS

On an individual basis, CBT appears to be efficacious in alleviating many child and adolescent disorders. Nevertheless, inclusion of the family is important considering that (a) many of the characteristics of a disorder in the child are also manifested in the family and (b) the etiology of many disorders may be due, in no small part, to parent or family factors such as poor modeling and communication styles, family hostility, an overcontrolling and authoritarian parenting style, and high enmeshment (Asarnow, Scott, & Mintz, 2002; Ginsburg & Schlossburg, 2002; McLaughlin et al., 2012). Indeed, the child or adolescent who is referred for therapy is often viewed as a "symptom" of discord in the family system. Although the inclusion of families in empirically-based CBT studies have only recently begun, there is evidence to suggest that family-focused CBT yields additional treatment gains above what is found using individual-oriented CBT (e.g., Wood, McLeod, Piacentini, & Sigman, 2009).

Including family members is also necessary for other reasons. For example, family members can assist the therapist in (a) ensuring that the children practice their weekly homework assignments, (b) helping the children catch their maladaptive cognitions as they occur, and (c) supporting the children as they face various stressful situations. Thienemann, Moore, and Tompkins (2006) found that training parents to serve as "lay therapists" (i.e., where specific skills were taught to help the parents work with their child) without working with the referred youth resulted in lower scores on parent- and clinician-reported measures of anxiety. However, clinicians who are considering

adapting CBT to the larger family unit should consider a number of factors that may limit treatment effectiveness. These factors include the severity of psychopathology in family members, the willingness of parents and other family members to enter therapy along with the referred youth (and vice versa), and the amount and type of resources that the family can provide.

Family-focused CBT techniques to treat anxiety and depression are adapted from those that are used in individual therapy. Such techniques include psychoeducation (i.e., teaching the family about the disorder and how communication and parenting styles may be contributing factors) and cognitive restructuring (i.e., exploring parents' distorted thinking about their child in a systematic fashion). Other techniques include facilitating effective communication between family members and the client (e.g., how conflicts occur and are resolved), providing contingency management skills (i.e., having the parents learn and apply effective behavioral modification techniques), and, if applicable, working with parents to explore their own struggles with the referred problem and how their struggles may be unwittingly modeled to the child (Ginsburg & Schlossberg, 2002). Wood et al. (2009) described specific components of their Building Confidence program, which was a manualized treatment that specifically targeted parents in the treatment of child anxiety. In addition to individual therapy with the child, parents were taught new communication techniques, including (a) giving choices when their child was indecisive (rather than making decisions for them), (b) allowing their child to struggle and learn through experience (rather than taking over for them), and (c) helping their child acquire novel self-help skills. In addition, a behavioral rewards system was also taught to parents, as well as planned ignoring (i.e., how to avoid attending to anxiety symptoms).

Parent interventions for traumatized children also parallel what is conducted in individual sessions (J. A. Cohen, Mannarino, Berliner, & Deblinger, 2000). Parents are often asked to go through an exposure phase where they discuss their thoughts and feelings about the child's traumatic event and perhaps recount the details about finding out about the trauma and dealing with the aftermath of the trauma. In the cognitive reprocessing phase, the therapist uses cognitive restructuring techniques to address the parents' distorted cognitions (usually around the areas of self-blame or in some cases blaming of the child). Finally, stress management is taught to the parent both for their own use and to model healthy reactions to both the traumatized child and other children in the household. Parents are also taught behavioral management strategies, where the traumatized child is not singled out as being "damaged" and needing extra leniency, or where the trauma was due to the child and therefore should be punished. Instead, parents are taught normal child developmental stages and are encouraged to treat the child with sympathy but also with an expectation that the child will behave in an age-appropriate manner.

CONSIDERING CBT GROUP INTERVENTIONS

There are many advantages to using CBT in a group setting, including (a) the ability to mimic real-world interactions with other people, (b) the possibility of practicing newly learned behaviors in session under the guidance of a therapist prior to trying them in the nontherapy world, (c) the potential for role-plays where the therapist can be the observer instead of a participant, and (d) the ability for clients to test the hypothesis surrounding their beliefs using feedback from other group member's experiences. The disadvantages of CBT in a group setting are similar to those found in any group treatment modality. For example, clients in group therapy may feel that they do not receive enough one-on-one individualized care and that they cannot probe deep enough into their own belief structure for fear of monopolizing the group. In addition, group dynamics can sometimes get in the way of the clients' ability or willingness to share their true thoughts, which they do more of in individual therapy. This may be especially the case among youth, where impression management and social desirability may be more pronounced than adults (considering that many of them are referred by teachers and parents, rather than self-referred). Further, group therapy may be limited and contraindicated for some disorders, including homogenous grouping of youth with conduct disorders. Strategies to reduce these disadvantages include explaining the purpose and role of group therapy to all clients before the group starts, conducting thorough screening of group members, asking the clients to create group rules that will make the group safe and productive for all group members, and offering individual therapy in conjunction with the group for those that require it.

In group therapy, as in individual therapy, the CBT therapist first conducts a check-in and asks to see if anyone has a pressing concern. The therapist, with the assistance of the group members, then creates an agenda (which may be partially predetermined if following a manual) and discusses the prior session's homework assignment. Introduction of a new topic of discussion follows, with the therapist teaching new information to the group. Finally, the therapist assigns homework for the next session and checks to make sure that any unresolved issues prior to the session have been addressed (White, 2000). Group treatments are typically conducted in a school setting by a school counselor or school psychologist or in a clinical setting by a mental health practitioner. Cognitive-behavioral therapy group models for children and adolescents have been created for the treatment of depression, anxiety (including panic and specific phobias), PTSD, bereavement, social skills training, eating disorders, attention deficit disorder, and parent training.

For example, Manassis et al. (2002) conducted a randomized study of CBT comparing 12 sessions of group and individual therapy with 78 8- to 12-year-olds suffering from childhood anxiety. The child received either group or individual therapy using

the *Coping Bear Workbook* (an adaptation of Kendall's (1990) *Coping Cat Workbook*). The focus of these sessions was on helping the child identify their physical reactions to anxiety, as well as teaching them how to relax, change their unhealthy self-talk, and to reinforce healthy coping skills. Both treatments contained a parental component with the parent either attending part of the individual sessions with the child or attending group therapy based on the book *Keys in Parenting Your Anxious Child* (Manassis, 1996). These groups approximately paralleled the work being done in the individual sessions with a focus on helping parents understand and deal with their child's anxiety and how to help their child cope with anxiety-provoking situations. The authors found that both parents and children reported a significant decrease in anxiety regardless of whether they received group or individual therapy, although children with high levels of social anxiety appeared to do better when they received individual therapy versus group therapy.

EFFICACY

Successful treatment of psychological disorders using CBT methods remains promising, with more than 325 published outcome studies using CBT interventions, although more work remains in this area (Butler, Chapman, Forman, & Beck, 2006). There is still some debate regarding the differential effectiveness of CBT over other forms of treatment, the type of control groups used to determine its effectiveness, and the long-term outcome of the reported changes. Recent meta-analyses have attempted to address these limitations (e.g., Michael & Crowley, 2002; Weisz, McCarty, & Valeri, 2006), and all indicate to a relative extent that CBT yields benefits above the use of medications and control groups. Nevertheless, there is disagreement about the strength of this benefit (as determined by the magnitude of effect sizes), and the ability of CBT to maintain at a long-term follow-up. Butler et al. (2006) examined existing meta-analytic studies and other high-quality research articles across 16 psychological disorders. Their findings suggest the CBT is "highly effective" for adolescent unipolar depression and childhood depressive and anxiety disorders. Cognitive-behavioral therapy was associated with high effect sizes for bulimia and more moderate effect sizes for childhood somatic disorders. The authors also examined CBT's strength over time and found that CBT does seem to have long-term effectiveness for childhood internalizing disorders. Based on their findings, the authors made several recommendations including the need to (a) apply CBT to a wider range of psychological disorders, (b) examine the long-term efficacy of CBT, and (c) compare CBT to alternative active treatments, not just to control groups.

Even in Butler et al.'s (2006) review, the authors acknowledge that some of their findings must be considered preliminary as the number of studies considered in parts of the meta-analyses is quite small. The dearth of studies can in part be related to the

relative youth of child treatments and difficulties in performing child and adolescent research. For example, it has only been relatively recently that childhood depression was a phenomenon that was outside the realm of normal development and was thus recognized as a legitimate field of study (Kovacs, 1989). Compounding this problem are numerous limitations in published child and adolescent treatment studies, including the lack of an adequate control group, use of different samples in one study (e.g., clinic- versus community-based samples), combining younger children with older youth, the inability to tease out the effects of medications from CBT gains, and differential diagnosis of disorders using various selection criteria and measurement instruments (Kendall & Choudhury, 2003). Given these limitations, it can be cautiously assumed that CBT works for some child and adolescent disorders, but additional research is necessary before definite conclusions can be drawn across the spectrum.

CASE STUDY

"Julie," age 14, was referred for CBT for behavioral, social, and academic difficulties stemming from abuse by her father at age 12. Her father was incarcerated for the abuse and Julie's mother had sole custody. The presenting problems included a dramatic change in personality from outgoing and bubbly to introverted and sullen, difficulties concentrating at school and a decreasing GPA, a diminished social circle, and anger outbursts and general noncompliance both at home and at school. An initial evaluation over the telephone with the mother suggested that Julie may benefit from therapy if she was willing to participate.

Assessment

An orientation and assessment session was scheduled with Julie and her mother that consisted of a structured interview with the mother and Julie together, separate interviews with Julie and her mother, and a standardized assessment battery that assessed the presence of mood disorders (including anxiety, depression, PTSD) with corroborating measures given to the mother. Results from these assessments yielded a number of conclusions. First, Julie met criteria for two mood disorders: PTSD and major depression, based on the most recent criteria specified in Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (American Psychiatric Association, 2013). Second, Julie felt that her mother blamed her for the break-up of the family and for not preventing the abuse, but she felt that she could not share these thoughts with her mother. Unbeknown to Julie, her mother had adopted a permissive parenting orientation with Julie, based on feelings of guilt that she "should have known something was happening" and because she felt that Julie was too vulnerable to handle "normal rules." Third, Julie acknowledged that she was having a tough time at school. She could not specify reasons

for her difficulty, other than to report that she could not concentrate and school no longer seemed to matter to her. Julie also stated that she was more irritable than before, which she attributed to the "stupid things" that people did around her that upset her. She reported that she wished that everyone would just leave her alone. Finally, Julie's mother noted that Julie had significantly changed her appearance since the abuse, and she now had several ear piercings and a nose piercing, wore baggy clothes, and had a short, spiked hair style that was sometimes painted blue. Julie shrugged her shoulders in response to her mother's statements about her dress, stating that "it was time for a change." The therapist conceptualized the problem to Julie and her mother and presented some treatment options, including cognitive processing therapy for sexual abuse (CPT-SA; Chard, 2005), a cognitive-behavioral treatment for PTSD and related symptoms. Julie decided that CPT-SA was something she would like to try, but she was concerned that her mother would not respect her privacy as she went through the treatment. She stated that she wanted some assurances from her mother that she would not attempt to be overly involved in the treatment, and her mother complied with this request.

Treatment Program

Cognitive processing therapy is offered in 12 to 17 sessions, depending on the type of trauma and the amount of distress that the individual is experiencing. The adapted version, CPT-SA, was designed specifically for childhood sexual abuse survivors and Julie and her mother opted for that option. Cognitive processing therapy for sexual abuse is multifaceted and sequentially ordered, with subsequent sessions building on skills learned in previous sessions. One important section of CPT-SA focuses on having the client understand developmental issues, and how childhood sexual abuse plays a role in shaping self-identity, attachment, self-concept, and self-esteem. The client's patterns of thinking and behaving that were established before, during, and after the abuse are discussed in detail. In addition, the client discusses with the therapist their developmental interruptions and experiences, helping them to understand the ways in which the three schematic levels most affected by sexual abuse (i.e., intraindividual, interpersonal, and worldview) are formed and reinforced through their interactions with others. Emphasis is placed on how cognitions and affect are tightly linked. Further, sexual abuse survivors often have less opportunity to develop extensive positive coping skills, because their thought processes are continually being mediated by their high levels of negative affect (e.g., sadness, fear, anger). This in turn can affect attachments both with family and peers. Thus, particularly in the first few weeks of therapy, sessions focus on labeling the full range of emotions for clients who often have a limited range of affect.

As the cognitions and emotions are addressed and adequately labeled by the client, subsequent CPT-SA sessions focus on seven belief areas including safety, trust, power/control, esteem, assertiveness/communication, intimacy, and social support.

Sexual abuse survivors commonly report ineffective or negative cognitions related to these seven themes. In each of these seven areas, CPT-SA helps clients refrain from distorting events to fit preexisting beliefs (i.e., assimilation) and encourages them to change their existing schemas to incorporate new information (i.e., accommodation). The intervention addresses schemas that have either been altered or confirmed by the abuse and identifies contextual factors that shaped these beliefs during the period of victimization. Although these negative cognitions may have served as adaptive coping mechanisms during the abuse, CPT-SA helps the individual identify disruptive schemas and incorporate more adaptive schemas that are more appropriate to current life situations.

In Sessions 1 to 3, Julie was educated about CPT-SA, her symptom disturbance, and characteristics that typify normal and abnormal development. During the initial sessions, the therapist also talked to Julie and her mother about PTSD, common reactions to PTSD, and ways in which Julie's mother could be of support during the treatment. The concept of "stuck points" or "rules" that Julie was using also were introduced to identify some distorted cognitions. A heavy emphasis was placed on understanding her family environment and the schema that developed from both the abuse and the family dynamics. Julie was asked to write an Impact of Event statement that described the ways in which she felt she had been affected by the trauma. Problem-solving sheets were used to help Julie identify ways in which events are tied to thoughts and feelings.

In Sessions 4 to 7, Julie was asked to process the abuse through a written recapitulation of the traumatic event(s). She read her written accounts most days at home and during each session to the therapist. Julie also continued to use the problem-solving sheets to process her thoughts and feelings about the abuse, and about everyday life events. In Sessions 8 to 10, Julie was encouraged to modify her cognitive distortions by using the Challenging Questions Sheet (CQS) and the Disruptive Thinking Patterns (DTP) sheet. These sheets allowed Julie and the therapist to examine evidence for and against her perceptions and to examine their basis. Finally, in Sessions 11 to 17, Julie learned to use the Challenging Beliefs Worksheet (CBW) to challenge her beliefs related to safety, trust, power/control, self-esteem, communication, intimacy, and social support. The CBW was a comprehensive worksheet that combines all of the sheets Julie had previously completed in therapy (e.g., the problem-identification sheet, the CQS, and the DTP). Additional questions focused on having her generate alternative thoughts and decatastrophizing possible future events.

At the concluding week, Julie was asked to rewrite her Impact of Event Statement, which she compared against her statement that was completed in the first session. Julie expressed that she was surprised to see how negative she was in the first session, including how angry she was at the world, and how certain she was that everyone knew she was an abuse survivor and they were judging her because of it. In the rewritten statement, Julie

noted that she was more in control of her thoughts and feelings and she was reacting to others typically after stepping back and evaluating the situation instead of mind reading and jumping to conclusions, which she had been doing.

Throughout the sessions, the therapist maintained a collaborative relationship by allowing Julie to decide which traumatic event she would write about first and by having Julie decide which thoughts needed to be challenged and which thoughts were part of her normal developmental process.

Parent Involvement

Stimulated by her discussion with the therapist, Julie allowed her mother to visit with her and the therapist during the last minutes of some sessions to talk to the therapist about Julie's progress and to discuss any concerns that the mother might have. At the end of Session 4, before Julie began recapitulating the traumatic event(s), the therapist explained to Julie and her mother that writing about the trauma can be very distressing and processed both Julie's and her mother's thoughts and feelings about completing this assignment. Julie's mother was encouraged to be supportive of Julie's need for privacy during this period and that she should be aware of Julie's potential for increased moodiness over the next 3 weeks.

Later sessions focused on communication between Julie and her mother. For example, in Session 11 Julie indicated that her mother "let her get away with anything" and she perceived this as an indication that her mother did not care what happened to her and saw her as a burden. The therapist led Julie through a CBW focused on Julie's belief that her mother does not care about her. Julie was able to identify an underlying belief that she believes she is to blame for the abuse and the break-up of the family and that she is assuming her mother feels the same way. This cognition was in turn challenged using the CBW and Julie agreed that she might want to do some reality testing to examine the situation with her mother. To that end, the therapist and Julie role-played how Julie could approach her mother about her thoughts and feelings, and what her mother's possible responses could be. Afterward, Julie talked to her mother with the therapist present and Julie was shocked when her mother began crying and stated that she blamed herself for Julie being hurt by her father. This interchange appeared to bring Julie and her mother closer and opened lines of communication regarding the trauma that had previously been closed. The therapist also discussed parenting roles and boundaries with Julie and her mother. Julie's mother acknowledged that she was not enforcing many rules at home and she agreed to work on setting more healthy boundaries with Julie. In Session 13, the therapist asked Julie's mother how the boundary setting was working. Julie and her mother reported that they felt that having more rules and structure was actually helping their relationship. Finally, the therapist met with Julie and her mother at the

end of Session 17 to talk about what therapy had accomplished, help plan for the future, and discuss ways to handle future stressors that might develop (e.g., the release of Julie's father from prison).

Evaluation

At the conclusion of therapy, Julie and her mother were asked to complete all of the assessment measures that they filled in a pretreatment (with the exception of historical measures, which would not have changed over time). At treatment completion, Julie no longer met criteria for PTSD or for major depression and her anger levels were significantly lower than what was reported at the initial session. Julie reported having periods of irritability, but she also stated that they were becoming less and less frequent. These findings were corroborated by her mother's assessments. Both Julie and her mother stated that one of the best parts of the therapy was their increased and positive communication between them. The mother also revealed that she was seeking therapy as well due to the significant positive improvements she was observing in her daughter.

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CHAPTER

6

Rational Emotive Behavior Therapy

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Albert Ellis is considered the grandfather of cognitive behavior therapy because he developed Rational Emotive Behavior Therapy (REBT), one of the original forms of cognitive-behavioral therapies (CBT). Ellis, a psychologist, psychotherapist, and philosopher, was one of the first psychotherapists to focus therapy on actively changing a client's present belief systems to achieve emotional or behavioral change. Although REBT was one of the first forms of CBT, it differs from CBT theories in several distinctive ways. REBT can be considered as part of the larger family of CBT interventions, yet maintains some distinctiveness. As a result, the literature on REBT often refers to REBT in two ways (Ellis, 2001, 2005a, 2005b). The term "classical REBT" refers to the distinctive features of REBT and the interventions and strategies that follow from these distinctive features. The term "general REBT" refers to the use of distinctive aspects of REBT plus the inclusion of other forms of CBT such as Beck's (2005) cognitive therapy, social problem solving therapy (Nezu, Maguth Nezu, & D'Zurilla, 2013) and self-instructional training (Meichenbaum, 1993). Thus, most REBT incorporate the classical, distinctive features of REBT while using the techniques of the wider field of CBT (Ellis, 2001, 2004). Early in its development REBT focused on the problems of children, adolescents, and parents (Bernard, Ellis, & Terjesen, 2006). In this chapter, we focus on describing classical REBT and its distinctive features, strategies, and techniques. A list of the distinctive features of REBT, as outlined by Dryden (2009), appears below. The reader is advised that in practice almost all REBT practitioners integrate classic REBT with interventions from CBT.

Distinctive Features of Ellis' Theory of Rational Emotive Behavior Therapy

- ABC model focuses on underlying irrational beliefs and not automatic thoughts.
- Rigidity is at the core of psychological disturbance.
- Flexibility is at the core of psychological health.
- Extreme beliefs are derived from rigid beliefs.
- Non-extreme beliefs are derived from flexible beliefs.
- The distinction between maladaptive or unhealthy negative emotions and adaptive or healthy negative emotions is qualitative not quantitative.
- Self-esteem is a dangerous, elusive concept.
- There is a distinction between ego and discomfort disturbance.
- People get upset about their emotional experience. Sometimes Cs becomes As.
- Humans are both biologically rational and irrational.

REBT is directive because the theory hypothesizes that certain types of cognitions cause or mediate disturbance and other types of cognitions promote adjustment. REBT recommends that psychotherapists focus on challenging the thoughts that lead to disturbance rather than wait for clients to self-discover the reasons for their problems. REBT is psychoeducational because it maintains that people can be taught the skills of identifying, challenging, and replacing their dysfunctional beliefs. REBT is philosophical because it takes specific positions on epistemology and recommends a philosophy of life. REBT is multimodal because it recognizes that people learn to think, feel, and act differently through many methods. Interventions from general CBT and many other forms of psychotherapy have been integrated with REBT. The system recommends the use of cognitive, emotive, imaginal, behavioral, and systemic techniques.

The trademark of REBT is its emphasis on teaching people to learn their ABCs of emotional disturbance, identifying the activating events, their beliefs about those events, and the resulting consequences. REBT teaches that disturbed emotional and behavioral consequences result from irrational beliefs individuals hold rather than from activating events. REBT works to alleviate emotional disturbance by helping people to (a) identify their irrational beliefs, (b) recognize that the irrational beliefs are maladaptive, and (c) replace those dysfunctional cognitions with more adaptive beliefs.

Ellis's writings include his personal philosophy, a recommended philosophy of life, a theory of psychopathology, and a theory of psychotherapy. While reading the REBT literature, one can encounter all of these elements. One could agree with aspects of Ellis's writings, such as his theory of psychopathology, and yet disagree with other aspects, such as his personal philosophy. For example, Ellis was an atheist. However, REBT is compatible with religious beliefs (DiGiuseppe, Robin, & Dryden, 1991; Nielsen, Johnson, & Ellis, 2001), and research has demonstrated that secular REBT and religious versions

of REBT are equally effective with religious clients (Johnson, Devries, Ridley, Pettorini, & Peterson, 1994; Johnson & Ridley, 1992).

HISTORY AND STATUS

Before becoming a psychologist, Ellis worked as an accountant while he pursued interests in music, literature, philosophy, and politics. He wrote operas and other musical scores, authored novels, and spent time as a political activist. During these years, Ellis was interested in romantic and sexual relationships and read voraciously on the topic, partly to overcome his own dating anxiety. Friends frequently approached him for romantic advice, and on their recommendation, he enrolled in the doctoral program in clinical psychology at Columbia University at the age of 40.

After completing graduate school in the late 1940s, Ellis started psychoanalytic training and simultaneously started to practice marital and sex therapy. Ellis became discouraged with the efficiency of psychoanalysis in the early 1950s. He realized that he helped clients in his sex and marital therapy practice more than those he treated with psychoanalysis. Initially, Ellis thought that he needed to dig deeper into his patients' pasts before they would improve. Yet, after they gained more insight, they still failed to improve. Ellis thought that years of insight into childhood experiences did not necessarily help patients and concluded that insight led to change in only a small percentage of individuals.

Ellis recognized that he behaved differently with clients in his marital and sex therapy practice. He actively taught these clients to change their attitudes. Ellis's interest in philosophy led him to the works of great Asian and Greek thinkers including Confucius, Lao Tze, Marcus Aurelius, and Epictetus. He had been advising clients based on these philosophical works. Ellis was intrigued by the philosophers' notion that people can choose whether or not they become disturbed, or in the words of Epictetus, "Men [and women] are not disturbed by things, but by the view which they take of them" (from the Enchiridion). Ellis utilized this philosophy as the foundation for his new therapy. In 1955, he formulated his theory in a paper delivered at the American Psychological Association. It was not until 1961 that his most influential self-help book with Robert Harper appeared, *A Guide for Rational Living*, now in its third edition having sold more than a million copies. The following year, Ellis (1962) published his first professional book, *Reason and Emotion in Psychotherapy*.

Ellis originally named his therapy "Rational Therapy" because he focused on the role of cognitions. He later realized that he had underemphasized the role of emotions in the title and renamed it "Rational Emotive Therapy." He finally changed the name to "Rational Emotive Behavior Therapy" (Ellis, 1994) at the urging of Ray Corsini. While revising his psychotherapy text, Corsini noticed that Ellis almost always used behavioral

interventions. He suggested that a new name would better represent what Ellis actually did and recommended it to Al.

In 1965, Ellis founded the Institute for Advanced Study in Rational Psychotherapy for professional training in his therapy. It survives today as the Albert Ellis Institute. Affiliated training centers that train mental health professionals exist in Argentina, Australia, Bosnia, Canada, Costa Rica, France, Germany, India, Israel, Italy, Mexico, the Netherlands, New Zealand, Pakistan, Paraguay, Romania, and Serbia. More than 13,000 psychotherapists throughout the world have been trained by the Institute or its affiliated centers. Ellis was a prolific writer and he published more than 60 books and more than 700 peer-reviewed journal articles. A bibliography of his writing is available at http://albertellis.org/albert-ellis-bibliography-page-1/. Prior to his death in 2007, *Psychology Today* described him as the "greatest living psychologist."

The institute sponsors the *Journal of Rational Emotive and Cognitive Behavior Therapies*, now under the editorship of Drs. Ray DiGiuseppe, Kristene Doyle, and Daniel David.

OVERVIEW AND THEORY

In the following section we detail the philosophical and theoretical assumptions of REBT, together with its view of psychopathology.

Philosophical Assumptions

As mentioned, REBT builds on some philosophical assumptions. The first of these is a commitment to the scientific method. Ellis believed that applying the scientific method to one's personal life would make one more likely to give up dysfunctional, irrational beliefs that lead to emotional disturbance and ineffectual behavior. Ellis's philosophy contains elements of constructivism, the philosophy of science, and epistemology. Specifically, Ellis maintained that all humans would be better off if they acknowledged that they create images or constructions of how the world is or ought to be. Ellis directly built his therapy on George Kelly's (1955) famous work, *The Psychology of Personal Constructs*.

Second, Ellis believed that people would be emotionally healthier if they recognized that all of their beliefs, schemata, perceptions, and cherished truths could be wrong. Testing one's assumptions, examining the validity and functionality of one's beliefs, and having a willingness to entertain alternative ideas helps one to develop new beliefs and schemata to guide one's behavior. Rigid adherence to any belief or schema of the world prevents one from revising one's thinking, and thus dooms one to behave as if the world is as one hopes it will be, rather than the way the world is. REBT differs from the Post-Modernist philosophers and the contructivist cognitive psychotherapists

such as Mahoney (1991) and Neimeyer (1993) in two ways (see Ruggiero, Ammendola, Caselli, & Sassaroli, 2014). First, the constructivist psychotherapists believe that the sole criterion to evaluate beliefs is their utility or viability. Empirical reality is not a criterion because the extreme constructivist approach maintains no knowable reality exists. REBT posits that empirical reality exists and it is important to assess the empirical veracity of one's beliefs along with their utility and logical consistency.

Second, modern constructivists believe that psychotherapists should wait for clients to find their own reality and not suggest alternative beliefs, as this represents an imposition of another's world view and is oppression. Constructivist psychotherapists believe that psychotherapists should not provide alternative beliefs for clients, but allow them to develop alternatives on their own. REBT posits that there are some rational alternative beliefs that will promote emotional adjustment.

REBT recommends (David, Lynn, & Ellis, 2010; DiGiuseppe et al., 2014, Ellis, 1994) that humans would function best if they adopted the epistemology of the philosophy of science, specifically the positions of Popper (1962) and Bartley (1987). Popper noted that all people develop hypotheses. Preconceived hypotheses distort the data one collects and lead to a confirmatory bias in reasoning. This renders objectivity in inductive data collection impossible. As humans, we cannot stop ourselves from forming hypotheses. The best solution is to acknowledge our hypotheses and attempt to falsify them. Popper maintained that knowledge accumulates and advances quickest when people deduce predictions from their hypotheses and collect data to disprove them. Bartley's epistemology of comprehensive critical rationalism adds that it is best if people use empirical falsifiablity tests, and any other argument one can muster to disprove one's thinking. Ellis believed that it is best to apply any and all means to challenge one's thinking as a theorist and as an individual. Accordingly, psychotherapists would do best to challenge their ideas about their clients and to teach their clients to do the same to their beliefs.

REBT maintains that certain values promote emotional adjustment and mental health (DiGiuseppe et al., 2014; Ellis, 1994). REBT practitioners attempt to develop attitudes and behaviors that reflect these values.

Values of Rational Emotive Behavior Therapy

Self-acceptance. Healthy people choose to accept themselves unconditionally, rather than measure themselves, rate themselves, or try to prove themselves.

Risk-taking. Emotionally healthy people choose to take risks and have a spirit of adventurousness in trying to do what they want to do, without being foolhardy.

Nonutopian. We are unlikely to get everything we want or to avoid everything we find painful. Healthy people do not waste time striving for the unattainable or for unrealistic perfection.

High-frustration tolerance. Paraphrasing St. Francis, healthy people recognize that there are only two sorts of problems they are likely to encounter: those they can do something about and those they cannot. Once this discrimination has been made, the goal is to modify those obnoxious conditions we can change, and accept, or lump, those we cannot change.

Self-responsibility for disturbance. Rather than blaming others, the world, or the fates for their distress, healthy individuals accept a good deal of responsibility for their own thoughts, feelings, and behaviors.

Self-interest. Emotionally healthy people tend to put their interests at least a little above the interests of others. They sacrifice themselves to some degree for those for whom they care, but not overwhelmingly or completely.

Social interest. Most people choose to live in social groups. To do so most comfortably and happily, they would be wise to act morally, protect the rights of others, and aid in the survival of the society in which they live.

Self-direction. We would do well to cooperate with others, but it would be better for us to assume primary responsibility for our own lives rather than to demand or need considerable support or nurturance from others.

Tolerance. It is helpful to allow humans (the self and others) the right to be wrong. It is not appropriate to like obnoxious behavior, but it is not necessary to damn the human for doing it.

Flexibility. Healthy individuals tend to be flexible thinkers. Rigid, bigoted, and invariant rules tend to minimize happiness.

Acceptance of uncertainty. We live in a fascinating world of probability and chance; absolute certainties probably do not exist. The healthy individual strives for some degree of order, but does not demand perfect certainty.

Commitment. Most people, especially bright and educated ones, tend to be happier when vitally absorbed in something outside themselves. At least one strong creative interest and some important human involvement seem to provide structure for a happy daily existence.

Theoretical Assumptions

REBT assumptions about psychopathology and change appear below.

These six principles can be summarized as follows:

1. Cognitions or beliefs are the most proximate and identifiable cause of human disturbance.
2. Irrational, illogical, and anti-empirical beliefs lead to unhealthy, disturbed emotions. Rational beliefs will lead to healthy, adaptive emotions and mental health.

3. The best way to change our emotional disturbance is to change our thinking.
4. Humans have a biological predisposition to learn to think both rationally and irrationally and to get themselves upset. However, culture and family teach people the specific issues that they will become upset about.
5. Both nature and nurture influence how and whether people develop unhealthy disturbed emotions; the reason people stay upset is because they rehearse their irrational beliefs and reindoctrinate themselves with what they were taught.
6. Change is difficult and people are most likely to change with repeated efforts to challenge their dysfunctional thoughts and rehearse new rational, adaptive beliefs.

Many theorists and practitioners ascribing to all forms of CBT think that cognitions cause emotions and behavior. A more modern view acknowledges that thinking, feeling, and behaving are interconnected elements, with each aspect of experience influencing the others. People think, feel, and behave simultaneously. It follows then, that what people think affects the way they feel, that people rarely feel and/or act without thinking, and that the way people behave influences what they feel and think. There are two implications of these theoretical assumptions.

First, one can assess one element of experience by asking the person to focus on that element while experiencing another element. For example, one can assess irrational beliefs by asking people to focus on what they are thinking while they are performing the target behavior or experiencing the target emotion. Second, psychotherapy includes cognitive, emotive, and behavioral techniques to achieve success. Cognitions might be the focal point of much discussion not because of their primacy, but because of their utility. People often can describe what they are thinking and entertain challenges to their thoughts or new thoughts easier than they can do new behaviors or "feel" emotions.

VIEW OF PSYCHOPATHOLOGY

The writing of Albert Ellis and other REBT theorists have included in their work a specific theory on the cognitive mechanism of psychopathology that differs from other cognitive approaches. This theory directly influences the content of its theory and practice of psychotherapy.

Adaptive and Maladaptive Emotions

REBT distinguishes between disturbed, dysfunctional emotions and normal, motivating, albeit negative emotions. The presence of negative emotions is not evidence of psychopathology. Negative emotions are adaptive (Darwin, 1872), and their elimination is not the goal of psychotherapy. If an activating event occurs (A) and one thinks

irrationally (B), one will experience a disturbed emotion such as anxiety or depression (C). If one then challenges one's irrational belief and replaces it with a rational belief (a new B), what will cause a new emotional consequence (the new C)? If the unpleasant activating event is still present, it would be inappropriate or unrealistic to expect a person to feel neutral or good after the challenging of his or her irrational beliefs. What does one feel if the intervention is successful? The answer is a negative, nondisturbed, motivating emotion. Some psychotherapists conceptualize therapeutic improvement as a quantitative shift in the emotion. Often psychotherapists ask clients to rate their emotion on the SUDS scale (Subjective Units of Discomfort) developed by Wolpe (1990). Therapy is successful if the SUDS rating demonstrates much less of the emotion.

Emotions differ by their intensity of physiological arousal, phenomenological experience, means of social expression, and the behaviors that they elicit. Ellis (1994; Ellis & DiGiuseppe, 1993) proposed that when people think rational thoughts, they actually experience a qualitatively different emotion rather than less intensity of the disturbed emotion. The emotions generated by rational thoughts will be in the same family of emotions as the disturbed emotion, but they differ in many aspects. Ellis posits that although irrational thinking leads to anxiety, depression, or anger, rational thinking will lead to concern, sadness, and annoyance, respectively. These emotions are not necessarily less intense but they may lead to qualitatively different phenomenological experiences, and to different forms of expression, and they will elicit different behavioral reactions. A good example of this principle is Dr. Martin Luther King Jr.'s emotional response to racism. Dr. King had an intense emotional reaction to racism, but it led to problem-solving, commitment, high frustration tolerance, and goal-directed behavior. The English language often fails to provide a lexicon to label such emotions. Emotional disturbance may correlate with the intensity of the physiological arousal but this is different from the intensity of the phenomenological feeling. Disturbance could also be characterized as an emotion that results in dysfunctional behavior or alienating social expression. Nondisturbed emotion elicits problem-solving, coping, and social cohesion. REBT focuses on the qualitative differences in emotion and rejects the notion, implicit in many theories, that emotions differ only quantitatively. Rational beliefs elicit adaptive emotions that lead to adaptive responses and social communications.

REBT utilizes the script theories of emotions (DiGiuseppe & Tafrate, 2007) and believes that clients need to learn adaptive emotional scripts, and not just change the intensity of their feelings. As a result, psychotherapists are very careful in the words they use to describe emotions and to help clients to choose which emotions they might like to feel in place of their disturbed emotion. They help clients formulate a vocabulary to describe adaptive, albeit negative, affective states that they could feel instead of the disturbed emotions.

Irrational Beliefs and Emotional Disturbance

Ellis originally identified 11 irrational beliefs that led to emotional disturbance (Ellis, 1994). Over the years, the list of irrational beliefs has dwindled to four and more recently (Ellis & Dryden, 1997) down to one, demandingness (David et al., 2010). The major theoretical problems REBT needs to address are: (a) which cognitive processes or irrational beliefs lead to emotional disturbance? And (b) how does irrational thinking initiate strong, sustained emotional disturbance?

There are a number of cognitive-behavioral therapies, each of which posits some type of cognitive process or cognitive content that leads to emotional disturbance and that is remediated by the respective therapy. A number of types of cognitions have been proposed to mediate psychopathology, such as attributions (Seligman, 1991), negative erroneous automatic thoughts (Beck, 2005), behavior guiding self-statements (Meichenbaum, 1993), beliefs in self-efficacy (Bandura, 1986), and core schemata (Beck, Freeman, Davis, & Associates, 2003). If psychotherapists are to develop treatment plans, it is important to understand all these constructs and how they may interact with each other and lead to psychopathology.

Originally, Ellis's theory presented irrational beliefs as ideas separate from these other constructs in a linear model of causation of emotional disturbance. Maultsby (1975) defined three criteria for irrational beliefs. To be irrational, a belief is illogical, inconsistent with empirical reality, or inconsistent with accomplishing one's long-term goals. These criteria are similar to those that Kuhn (1970), the historian of science, proposed scientists use to evaluate theories: logical consistency, empirical predictability, and heuristic or functional value.

Irrational beliefs were originally conceptualized as being independent from the constructs of other cognitive theories because they were more evaluative in nature. This distinction failed to be maintained because some of Ellis's original irrational beliefs are factual errors. Irrational beliefs actually have the same characteristics as rigid, inaccurate schemata (David et al., 2010; DiGiuseppe et al., 2014; Dryden, DiGiuseppe, & Neenan, 2010). In fact, DiGiuseppe (1996) and Ellis (1996) proposed that it would be more accurate to call them irrational schemata than irrational beliefs. REBT construes irrational beliefs as tacit, unconscious, broad-based schemata that operate on many levels. Schemata are sets of expectations about the way the world is, the way it ought to be, and what is good or bad in what is and ought to be. Schemata help people organize their world by influencing (a) the information to which a person attends; (b) the perceptions the person is likely to draw from sensory data; (c) the inferences or automatic thoughts the person is likely to conclude from the data one perceives; (d) the beliefs one has in one's ability to complete tasks; (e) the evaluations a person makes of the actual or perceived world; and (f) the solutions that a person is likely to conceive to solve problems.

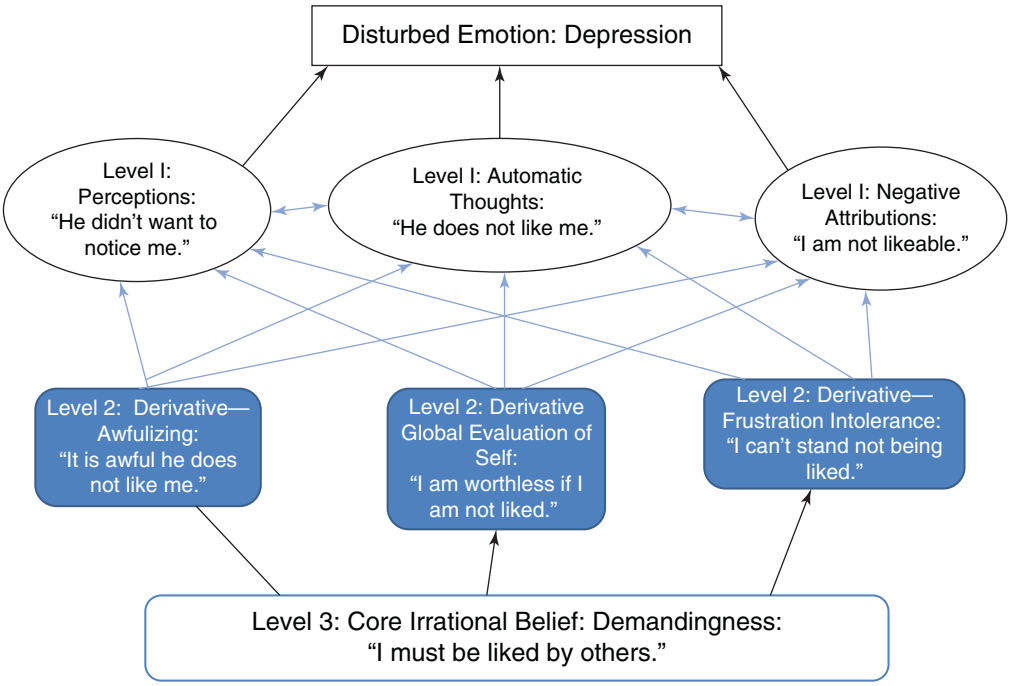

Disturbed Emotion: Depression
Level I: Perceptions: "He didn't want to notice me."
Level I: Automatic Thoughts: "He does not like me."
Level I: Negative Attributions: "I am not likeable."
Level 2: Derivative—Awfulizing: "It is awful he does not like me."
Level 2: Derivative Global Evaluation of Self: "I am worthless if I am not liked."
Level 2: Derivative—Frustration Intolerance: "I can't stand not being liked."
Level 3: Core Irrational Belief: Demandingness: "I must be liked by others."

Figure 6.1 Three Levels of Cognitions Leading to Emotional Disturbance. *Source:* Adapted from The Three Levels of Cognitions Influencing Emotional Disturbance. From DiGiuseppe et al. (2014).

Conceptualizing irrational beliefs as schemata means they are both factual and evaluative in nature. They predict what is and what is good. Irrational beliefs/schemata influence other hypothetical cognitive constructs that are mentioned in other forms of CBT. Figure 6.1 represents how irrational beliefs relate to other cognitive constructs and emotional disturbance. The model suggests that interventions aimed at the level of irrational beliefs/schemata will change other types of cognitions as well as emotional disturbance; interventions aimed at other cognitive processes may, but will not necessarily, influence the irrational schema.

Modern REBT proposes that at least three levels of cognitions lead to emotional arousal and disturbance (shown in Figure 6.1). The first level of thoughts that immediately occurs is what William James (1890/1950) referred to as the stream of consciousness. Most people have a consistent monologue going on in their heads throughout their waking hours. These initial, first-level cognitions are inferential in nature. All humans have their own, unique perceptions of reality. Inferential cognitions are the conclusions one draws from these perceptions. For example, suppose you are walking down the school corridor and see a fellow student approaching you. You wave your arm in greeting, but your gesture is not returned. You might infer from this event that the student did not

see you. Or, you could infer that the student saw you and decided not to greet you. You could even go further and infer that the absence of a greeting has some interpersonal meaning; perhaps the student is angry with you or does not like you, or that no one at work likes you. These cognitions could be incorrect inferences, which can take the form of negative perceptions (e.g., "She/he doesn't like me"). These inferences can be tested by collecting evidence for and against your conclusions to determine if they are actually true. Many of these inferential cognitive constructs have been associated with emotional disturbance and psychopathology (Beck, 2005).

The second-level cognitions are largely evaluative and are referred to in REBT as derivative irrational beliefs or evaluative beliefs—these are awfulizing, global evaluation of self/other/world, and frustration intolerance. REBT recognizes that these evaluative cognitions are more central to emotional disturbance than first-level inferential cognitions. The first-level inferential cognitions are correlated with psychopathology not because they are causative, but because most disturbed people hold these deeper levels of beliefs that evaluate and give importance to the first-level inferences, making them more significant in the development of emotional disturbance. These three types of second-level beliefs (awfulizing, global evaluation of self/other, and frustration intolerance) evaluate the significance of the possible reality portrayed in the inference, the worth of the persons involved if the inference is true, or one's appraisal of one's ability to cope with or tolerate the perceived situation. Awfulizing is an exaggeration of the negative consequences of a situation to an extreme degree, so that an unfortunate occurrence becomes "terrible." Global evaluations of human worth, either of the self or others, imply that human beings can be rated as entire beings, and that some people are worthless, or at least less valuable than others. Frustration intolerance (also known as *low frustration tolerance*) stems from demands for ease and comfort, and reflects an intolerance of discomfort. We call these beliefs *derivatives* because REBT posits that they are psychologically deduced from the more core schematic irrational beliefs.

The third level of cognitions is schematic demands or imperatives, and they represent the core irrational beliefs (IBs). These beliefs are tacit, sometimes unconscious, broad-based schemata. Many REBT and CBT therapists use the term *unconscious* to mean thoughts/beliefs that are out of our awareness, however, they can be accessed. Irrational beliefs are derived from the more central imperative demands, which are one's thoughts about the way reality should be. With these thoughts people construct a philosophy about the world as they want it to be, not necessarily as it is. REBT posits that rigid thinking and the inability to accommodate to new information is the foundation of emotional disturbance. REBT maintains that cognitive flexibility, adapting to new situations, and incorporating new information into personal schemata represents the core of psychological adjustment.

Because core irrational demandingness represents schemata, they serve the function of schema. They help people organize their world and influence aspects of thought such as: (a) the information to which a person attends, (b) the perceptions the person is likely to draw from sensory data, (c) the inferences or automatic thoughts the person is likely to conclude from the data he or she perceives, (d) the belief one has in one's ability to complete tasks, (e) the evaluations a person makes of the actual or perceived world, and (f) the solutions that a person is likely to conceive to solve problems. Irrational demandingness beliefs/schemata influence other hypothetical cognitive constructs that are mentioned in other forms of CBT, such as perceptions, inferences, or negative automatic thoughts, and global, internal attributions of cause. Thus, REBT proposes that the demandingness beliefs are the cause of the other dysfunctional thoughts such as negative automatic thoughts, erroneous attributions, and overly negative evaluations.

The discrimination between inferential cognitions, evaluative cognitions, and imperative/schematic cognitions (irrational beliefs) sets REBT apart from other forms of CBT. REBT acknowledges the importance of inferential processes and might use techniques to change these distorted cognitions. However, REBT recommends that therapy focus more on the level two and three cognitions. According to REBT, even if one thinks negative automatic thoughts, one can protect oneself from emotional disturbance about such potential realities if one thinks about them rationally, and give up the demand that such events must not happen.

People can have irrational beliefs about different content areas. The most common of these would be affiliation (being accepted or rejected), achievement (doing well or failing), comfort, and fairness. A model of irrational beliefs is shown in Table 6.1. On the horizontal dimension are types of irrational processes and on the vertical dimension there are the content about which the person thinks irrationally. REBT proposes some hypotheses concerning which irrational beliefs are most involved in specific disorders. For example, global rating irrational beliefs about the self, most likely play a major role in depression, while global rating of others will lead to anger and contempt. Irrational beliefs about comfort with our emotional experiences have been proposed to play a prominent role in agoraphobia (Burgess, 1990). Awfulizing beliefs will lead to anxiety. Frustration intolerance irrational beliefs have been considered to be a crucial factor leading to procrastination.

Next we discuss these four irrational beliefs in more detail.

Demandingness

Demandingness is represented in English by the words "must," "should," "ought," and "have to." These words reflect a demand on how oneself, others, or the world must be. REBT makes the distinction between preferences and demands. Preferences are neither rational nor irrational, they just are. Psychotherapists do not attempt to change a person's

Table 6.1 Model of Irrational Beliefs from DiGiuseppe et al. (2014)

Model of Irrational Beliefs						
		Irrational Process				
		Demandingness	**Frustration Intolerance (FI)**	**Awfulizing**	**Self-Worth Ratings**	**Other-Worth Ratings**
Belief Content	**Social Relationships**	Demanding about affiliation	FI about affiliation	Awfulizing about affiliation	Self-condemning about affiliation	Other-condemning about affiliation
	Achievement	Demanding about achievement	FI about achievement	Awfulizing about achievement	Self-condemning about achievement	Other-condemning about achievement
	Comfort	Demanding about comfort	FI about comfort	Awfulizing about comfort	Self-condemning about comfort	Other-condemning about comfort
	Fairness	Demanding about fairness	FI about fairness	Awfulizing about fairness	Self-condemning about fairness	Other-condemning about fairness

"wants." To quote Zajonc (1980), "Preferences need no inferences." REBT posits that it is okay to want anything and no desire is a sign of pathology or normalcy except in the statistical sense. People's desires do not cause disturbance. However, when people demand that their preferences are reality, they become disturbed. But how and why does demandingness lead to disturbance?

Piaget (1963) noted that people revise their schema by assimilation or accommodation. REBT posits that people construct schemata of the world. Research has demonstrated that when people hold a schema and reality is discordant with their expectations, emotional upset occurs. The crucial event here is that our sensors detect information that is inconsistent with our expectations. When such a reality-expectation discrepancy occurs, people become startled or upset. Well-adjusted people become motivated by this emotional arousal to seek out further information and will revise their schema to be consistent with reality. That is, they accommodate their schema to fit reality.

REBT posits that disturbed individuals continue to hold onto their existing schema and demand that the world be consistent with their conception of it. This results in increased emotional upset as their sensory information continues to supply information that the world is not complying. Thus, demandingness is actually believing and expecting that the world will be the way one prefers it to be. That is, they assimilate the discrepant information into their existing schema.

For example, an adolescent girl might think, "My parents must treat me fairly and let me do what I want." Not only does she want her parents to allow her to do as she desires, but she believes that because she wants it, they must comply. She may be shocked when they punish her for transgressions of their rules, and she may continue to behave against their rules despite all the feedback that they disapprove of the behavior and will initiate consequences for it. Also, she may conclude that "Because I must do what I want, I cannot stand it if they do not let me." Or "It is terrible and awful if my parents do not let me do what I want."

Some irrational beliefs include demands about what one must do to be a worthwhile, valued person. For example, a recent client, Melissa, age 11, believed that she must be liked by a certain "in group" of peers in her class to be a "good person." Melissa demanded that she be liked by this group of girls, and she recognized that they did not like her. Her demand was of her self-worth. She said "I must have their approval to be worthwhile." Her schema of human worth was rigidly linked to approval by certain others. No other characteristics counted. Attempts to demonstrate that she possessed other exemplar traits and that she was esteemed by her family, teacher, and some peers outside the "in group" failed to change her self-worth. She neither assimilated nor accommodated her schema of her self-worth. Her demand was not on the way the world or others were, but on the criteria for her self-acceptance or worth.

Rational beliefs express preferential, flexible desires, whereas irrational cognitions express absolutistic, rigid needs. Rational beliefs leads to happiness and enables individuals to attain their goals and strive toward their potential; irrational beliefs lead people to be extremely disturbed and thwart the individuals' ability to attain their goals, leading to unhappiness.

Awfulizing

These beliefs are characterized by exaggerated negative evaluations and thoughts that something about oneself, others, or the world is terrible, awful, or catastrophic. One might say that, "It is awful if I do not have the approval of everyone around me." Rorer (1989) suggested that when people hold such a belief they are unable to define just what awful or terrible is, or what catastrophe will occur. They are, in fact, uncertain of the outcome and define it as extremely bad. Rorer believes awfulizing is definitional. People arbitrarily assign an extremely negative valence to an event and never test reality to see if the occurrence of the event brings such negative consequences. The empirical argument against awfulizing thinking is best summarized by Mark Twain who said, "I have survived many a catastrophe that never occurred." Rational thinking would acknowledge that some things are bad, but stress that they are survivable.

Frustration Intolerance

Ellis (2003a, 2003b) originally called this type of irrational belief *low frustration tolerance*, or LFT. Such beliefs imply that individuals cannot stand something they find frustrating, or that the individuals do not have the endurance to survive in its presence. For example, someone who is addicted to caffeine might say, "I cannot stand feeling the slightest bit tired when I have all this work to do; I must have some coffee." These beliefs are illogical as well, because, short of dying, one is actually tolerating whatever one claims one cannot stand. The term *frustration intolerance* (FI) appears more appropriate than Ellis's term low frustration tolerance. Australian psychologist Dr. Marie Joyce pointed out that the term LFT can invalidate clients' difficulties. While Dr. Joyce was working with parents of neurologically disabled children, she had difficulty getting these parents to follow behavior management strategies. The parents commented that it was too hard, and that they could not stand being so consistent with their children when they misbehaved. When Dr. Joyce challenged the parents' LFT, they felt misunderstood. Dr. Joyce admitted that these parents had more difficulty raising their children than most other parents. In fact, they had been tolerating more frustration than most parents. The problem was not that the parents had LFT, but that they did not have sufficient frustration tolerance. They needed to have greater frustration tolerance than the average parent if they wished to accomplish their goal of getting their children to behave better. Dr. Joyce

suggests that the unwillingness to sustain or tolerate the degree of frustration necessary to achieve one's goals be labeled *frustration intolerance*. This prevents psychotherapists from invalidating the difficulties of people who are intolerant of the frustration needed to accomplish their goals but who have experienced more frustration than most people.

Global Condemnation of Human Worth

These beliefs consist of negative evaluations of oneself, others, or the world, such as "I must be worth*less* if I do not have the approval of everyone around me." Ellis (1994, 2005c) stated that a person cannot be rated as either good or bad because it is not possible for one to be completely good or bad due to people's complexity. Instead, ratings should be restricted to people's behaviors. It is more logical, and certainly healthier to state that "I performed poorly on the math test," instead of saying in addition, "therefore, I am a bad student." Ellis's position is a philosophical one. He proposed that people take seriously the Preamble to the U.S. Constitution or the Judeo-Christian religious tradition, both of which state that all persons are created equal, the former by government and the latter by God. REBT teaches people to rate their deeds and not themselves. As the proverb goes, "Hate the sin, but love the sinner." Self-evaluations are replaced with what Ellis calls USA, *unconditional self-acceptance* (see Bernard, 2013, for the most updated review of this concept).

REBT opposes the self-esteem movement popular in education today. Self-esteem is a combination of two different cognitive processes. The first is self-efficacy, which is the belief that one can in fact adequately perform a task. If you search the items of self-esteem scales, you will notice that many items reflect this type of statement. The second is self-evaluation. This involves making conclusions about one's worth as a person. Humans often get these two confused and evaluate their worth, or lack of it, based on perceived self-efficacy or lack of it. For example, an adolescent recently seen in psychotherapy concluded that because he could not read as well as other children did, he was "no good" as a person. He had negative self-efficacy and negative global self-evaluation.

Bernard, Vernon, Terjesen, and Kurasaki (2013) have discussed the concept of self-acceptance versus self-esteem in children and adolescents. They argued that self-esteem programs either teach children that they are special or good people because they are efficacious or that they directly teach people unwarranted self-efficacy. REBT points out two difficulties with such programs. First, they teach the children that they have self-worth because of self-efficacy. This could be fine for the moment; but what if their skills falter or they are surpassed by their peers to a great degree? The mental health of such children could be on a roller coaster. They feel good when they perform well, and they feel worthless when they perform badly. Second, these programs often teach self-efficacy beyond the child's skills. They are likely to collapse emotionally when they can no longer get feedback that they are effective. Third, self-esteem programs

fail to provide coping strategies for poor performance. Because most people fail on the way to success, or fail more often than they succeed, people need to cope with performing poorly.

Consider the case of an 8-year-old special education student originally referred for depression and social isolation. Another professional had taught him to play basketball and had taught him that he was special because he had done well at basketball. The boy was fine for several days, until he bragged about his athletic skills to some neighborhood peers. When they trounced him in a game, he became depressed. Teaching children that they are worthwhile people even when others outperform them or when they perform poorly is most important for working with many of the exceptional children we encounter.

As mentioned, each of the irrational beliefs can be applied to oneself, others, or the world. Ellis proposed that irrational beliefs directed toward the self often result in depression, anxiety, obsessiveness, self-hatred, and even suicide. Irrational beliefs directed toward others frequently lead to feelings such as anger, contempt, and rage. Moreover, irrational beliefs about the conditions of the world can lead to depression, anger, and dysfunctional behaviors such as procrastination and addiction (David et al., 2010).

Table 6.2 presents examples of common referral problems of children and adolescents, their behavioral and emotional consequences, and corresponding irrational beliefs (Griger & Boyd, 1989).

Research Support

Many studies have correlated irrational beliefs to measures of emotional disturbance. However, little research specifically tests Ellis's revised theory, that demandingness is the core irrational belief from which all the others are derived and that emotional disturbance can be explained best by demands people put on themselves, others, and the world. The empirical evidence does not totally support the revised theory. It has been found (see Kendall et al., 1995; and David et al., 2010, for reviews) that subscales of frustration intolerance (FI) and self-downing beliefs correlate more strongly with emotional disturbance than subscales of demandingness or awfulizing beliefs. Also, several factor analyses have indicated that there are two distinct categories of irrational beliefs. These studies have found that demandingness, awfulizing, and frustration intolerance items factor together, as Ellis had assumed they would. Thus, demandingness, awfulizing, and FI could be different aspects of the same psychological construct. Items reflecting negative self-ratings loaded on as separate factors by themselves (Bernard, 1998; DiGiuseppe, 1988). Some research has shown (David et al., 2010; David, Schnur, & Belloiu, 2002; Smith, Haynes, Lazarus, & Pope, 1993) that both demandingness as primary appraisal process and awfulizing as secondary appraisals are significant predictors of high anxiety, while depression is predicted by demandingness (primary appraisal) and self-downing

Table 6.2 Referral Problems, Behavioral Consequences, Emotional Consequences, and Corresponding Irrational Beliefs

Problem	Behavioral "C"	Emotional "C"	Irrational Beliefs
Withdrawal, avoidance	Avoidance of people and tasks, shyness, and dependency	Anxiety and fears Feelings of inferiority Depression (secondary)	I must do well and be approved of. I must avoid getting noticed at all costs, because if I try, I will fail and be disapproved of. That would be terrible and I would be worthless. So as long as I can be left alone and nothing is demanded of me, my worthlessness will not be obvious and I won't feel worthless.
Perfectionism	Compulsiveness, overachieving, overdriving to excel	Feeling okay when they succeed Anxiety before performance Depression, guilt, self-downing when they fail	I must do well in order to get attention and be approved of or else I will be lost and worthless. I must always do my very best. My performance at school and everywhere else should always be competent. It's terrible to do poorly and doing poorly shows what an incompetent person I am. If I don't totally and always do well, then I'm totally and always a failure.
Attention seeking	Acting as the model child, cute, charming, acting as the class clown, showing off, pestiness, helplessness, dependence	Anxiety Feelings of inferiority Depression (secondary)	I must be noticed at all costs or else I am lost and worthless. I must be loved and approved of, all the time. It's awful to go unnoticed or unacknowledged.
Power struggles	Disobedience, stubbornness, uncooperativeness, "Smart-mouthing," hostility toward students who do not agree	Anger Jealousy	The only way I can feel like somebody is to defy pressure and do what I want. I must win, because if I don't I am a loser. People must acknowledge that I am right. I must be on top. People should give me attention and approval by making me Number 1.
Procrastination	Laziness, sloppiness, self-indulgence, grousing and griping, noncompliance with assignments	Frustration Self-pity Resentment	I shouldn't have to work so hard to get things done. I can't stand to do these boring things necessary to reach some goal. It's too hard and it takes too much work. I can't stand to delay pleasure. Because I don't like it and it's not fair, I should not have to do it. It's easier and better to take one's pleasure now rather than get pleasure later.
Revenge	Bullying, passive/ aggressive noncompliance, stealing, aggression	Anger Resentment Jealousy	People should/ought/must do right by me. People who do wrong by me are wicked and blameworthy and deserve to be punished and to suffer. Those who do not give me attention deserve to be hurt. I must feel significant, and the only way I can feel significant is to hurt others as much as I can.
Depression	Lethargic behavior, excessive sleeping, significant loss or increase of appetite, withdrawing, verbal expression of helplessness and hopelessness	Guilt Depression	I did a bad thing and I'm a bad person for having done it. I must be totally competent and loved or else I'm worthless. This is a hassle; it's too much of a hassle; I can't stand it. Poor me.

(secondary appraisal). More recently David et al. (2014) obtained similar findings using qualitative methodology of coding the ABC models of trainees. There have been, however, no direct tests of the idea that demandingness is the core from which the other irrational beliefs emerge.

Recent studies document the mediating role of specific irrational beliefs for the link between general irrational thinking and parenting distress. Moreover, in support of the elegant solution, they found that global evaluation of worth is proximal to parental distress and mediating its relationship with self-efficacy and locus of control, while unconditional self-acceptance is proximal to parental satisfaction.

Primary and Secondary Disturbance

REBT posits two types of disturbances that result from irrational thinking. Primary emotional-behavioral disturbance arises when one thinks irrationally about concrete activating events. Secondary emotional-behavioral disturbance occurs when one thinks irrationally about ones' primary emotional-behavioral disturbance. That is, the emotional consequence of a primary ABC becomes an activating event for a new ABC. Because people not only think about events they experience but also reflect on their own cognitions, emotions, and behaviors, irrational beliefs about one's own thoughts, feelings, and actions often lead to secondary emotional disturbance. People can get depressed about being depressed, anxious about their anxiety, and angry at themselves for getting angry. Secondary emotional disturbance maintains one's disturbed state. Considerable research exists to support the importance of this secondary emotional disturbance in the areas of anxiety disorder, and especially panic disorder. Barlow (1991) has gone so far as to state that all emotional disorders may be secondary disturbance. He believes that people often produce secondary disturbance after they experience nondisturbed emotions because of frustration intolerance over experiencing the nondisturbed emotions.

When a secondary disturbance does exist, attempts to intervene at the level of the primary disturbance usually fail. Whenever people think about how they upset themselves or what strategies they could use to overcome their primary disturbance, they elicit their catastrophic thinking or frustration intolerance and bring on the secondary disturbance. REBT recommends that psychotherapists treat the secondary disturbance first, and when finished, focus on the primary disturbance (DiGiuseppe et al., 2014; Dryden et al., 2010; Ellis & Dryden, 1997). Several other theorists have come to similar conclusions and recommend that clients learn to tolerate their emotional disturbance as a means of preventing further escalation of their problems (Hayes, Strosahl, & Wilson, 1999; Jacobson, 1992).

THERAPEUTIC STRATEGIES AND TECHNIQUES

Below we will detail the strategies and techniques used in REBT with children, adolescents, and their families.

Unconditional Acceptance

Early in the history of psychotherapy, Ellis and Rogers (Ellis, 1959, 1994; Rogers, 1957) often debated the necessary and sufficient conditions for behavior change. Rogers believed that unconditional acceptance of the client by the psychotherapists was necessary and sufficient for human change. Ellis (1959) disagreed. He believed that unconditional acceptance of the client was neither necessary nor sufficient. However, he believed that it was highly facilitative of change.

Ellis (1959, 1962) believed that unconditional acceptance is not necessary for change because many people change without it or even without psychotherapy. People can change on their own by bibliotherapy, modeling, or other experiences. Recently research by Norcross, Krebs, and Prochaska (2011) has focused on how people change without therapy. They have found that a "relationship" is one of many processes that can lead to change. Ellis believed that unconditional acceptance is not sufficient for change because people who are unconditionally accepted must draw some conclusions about themselves based on the experiences of being accepted. Thus, some cognitive restructuring could result from these relationships. Many disturbed people who experience unconditional acceptance from psychotherapists have not changed. Once people deduce something about themselves because they have received unconditional acceptance, they need to rehearse it, because they will still have the same old well-rehearsed belief that they are worthless. Some people develop self-acceptance without the help of others.

Many people have the misconception that REBT disregards the therapeutic relationship, and much of the literature on REBT has spent little time discussing the issue. Ellis (1994; DiGiuseppe, 2011) always acknowledged that unconditional acceptance of the client is a crucial part of therapy. Research indicated that psychotherapists practicing REBT at Ellis's Institute establish excellent therapeutic relationships with their clients (DiGiuseppe & Leaf, 1993). Ellis's theory places a major emphasis on the role of self-devaluation as a cause of psychopathology, and attaining unconditional self-acceptance (USA) as a means of becoming emotionally adjusted. One place where clients can learn USA is from their psychotherapists' acceptance of them.

REBT maintains that psychotherapists' acceptance of their client is a crucial part of therapy for several reasons. First, it provides a model for clients that their worth as people is not linked to any specific behavior. Second, the psychotherapists' acceptance of clients might be necessary if clients are to reveal their secret emotions, acts, or thoughts to the psychotherapists. Also, clients are much more likely to listen to their

psychotherapists and follow their advice if the clients are accepted by their psychotherapists. Third, psychotherapists also coach their clients to practice new ways of thinking and feeling about themselves.

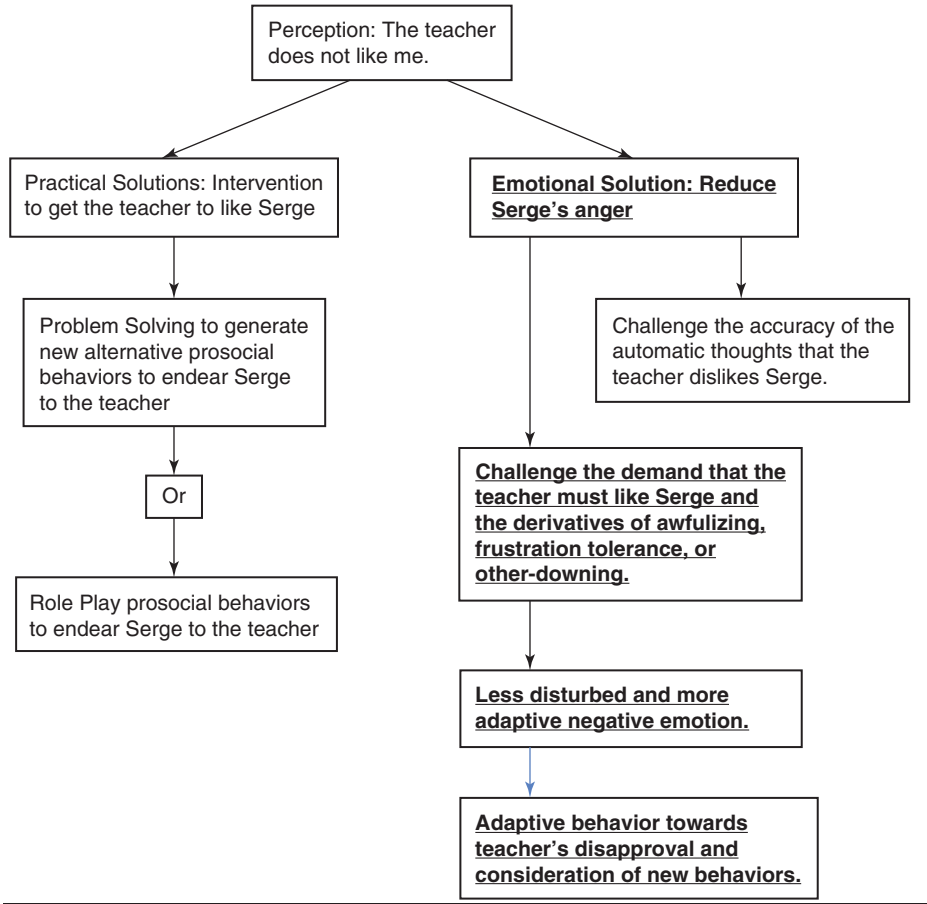
All psychotherapists, to be effective, need to learn how to communicate acceptance to their clients, and to develop an accepting attitude toward all humans, which will enable them to actually feel acceptance toward their clients.

This behavioral and emotional skill is difficult to maintain when treating narcissistic, defiant, aggressive, or conduct-disordered children and adolescents. Often psychotherapists are confronted by children and adolescents who do despicable acts. How do we accept them? Recently, one of us (RD) treated a 15-year-old sex offender who chose kindergartners as victims. The client enjoyed and desired sexual contact with these young victims. Will accepting him lead him to falsely conclude that his psychotherapist approves of his performing such behaviors? If the psychotherapist takes a strong disapproving stand, will the boy reveal any more of his thoughts and desires to the psychotherapist again? These are the dilemmas that one faces daily in therapy. REBT (DiGiuseppe et al., 2014) has adopted a view also proposed in psychoanalytic therapy (Sherwood, 1990). It is important for psychotherapists to acknowledge and accept clients with the clients' aberrant desires. However, it is also important to express disapproval of acting on the desires, while accepting clients even though they have acted on such desires. Developing such attitudes toward humans may be a prerequisite for becoming an effective psychotherapist.

Practical versus Emotional Solutions

REBT distinguishes between practical and emotional solutions (DiGiuseppe et al., 2014; Ellis, 1994). A practical solution involves a problem-solving or skill-development approach that helps the client change the activating event. An emotional solution attempts to change the client's emotional reaction to the activating event. Practical solutions try to change the As; emotional solutions try to change the Cs. For example, consider the case of a middle school child, Serge, who was disrespectful and angry with a teacher. Serge thought that his teacher disliked him because of the way he talked and the style of his clothes which, based on Serge's reports, seemed accurate. Serge regaled in his "hip-hop" garb and slang, and the teacher made it clear that she found his choices unacceptable. One therapeutic strategy is to teach Serge to behave toward the teacher in a manner that would endear Serge to the teacher. This is a practical solution designed to change the activating event, the teacher's disapproval of Serge. REBT recommends that psychotherapists seek an emotional solution first, for reasons that are apparent in the preceding case. Often there are no practical solutions, and clients must "bite-the-bullet" and learn to cope with harsh realities. Second, clients are more likely to learn problem-solving and behavioral skills after they have achieved

Table 6.3 Comparison of the Practical and Emotional Solutions to Serge's Problem


Perception: The teacher does not like me.
Practical Solutions: Intervention to get the teacher to like Serge
Emotional Solution: Reduce Serge's anger
Problem Solving to generate new alternative prosocial behaviors to endear Serge to the teacher
Challenge the accuracy of the automatic thoughts that the teacher dislikes Serge.
Or
Challenge the demand that the teacher must like Serge and the derivatives of awfulizing, frustration tolerance, or other-downing.
Role Play prosocial behaviors to endear Serge to the teacher
Less disturbed and more adaptive negative emotion.
Adaptive behavior towards teacher's disapproval and consideration of new behaviors.

the emotional solution. In the case of Serge, REBT would recommend an emotional solution for several reasons. First, Serge might never succeed in getting the teacher to like him, and he might always have to deal with her rejection of him. Second, it is hard to improve your relationship with someone at whom you are angry. Serge would be more likely to endear himself to the teacher if he gave up his anger. Table 6.3 shows the alternative for the practical and emotional solutions that could be used in Serge's case. The REBT interventions are in boxes with bolded and underlined text.

Some trainees misinterpret REBT's strategy of seeking the emotional solution first to mean that REBT only works on the emotional solution. They think that helping clients achieve the practical solution is selling out the stoic philosophical roots of REBT. However, one of REBT's goals is to have clients lead happier lives. People can do this best if they can tolerate and handle hassle. It is not consistent with the theory that people should tolerate frustration when they don't have to. However, REBT recommends

that this intervention be done after an emotional solution, in case there is no practical solution, and because clients are best able to pursue practical solutions when they are not disturbed.

Philosophical/Elegant versus Inelegant Solutions

REBT posits that psychotherapists will help clients best achieve emotional solutions by changing clients' core irrational beliefs instead of changing clients' perceptions or automatic thoughts. Ellis referred to such interventions as "the elegant solution." Ellis considered the philosophical/elegant solution preferable because it provides clients with a coping strategy that can be used to deal with a wide number of similar and possibly more negative activating events. Philosophical solutions promote more generalizable change across a wider array of situations.

REBT posits that psychotherapists avoid interventions focused at changing perception through reattributions or reframing, or correcting negative automatic thoughts. Ellis called such interventions "inelegant." He considered them inelegant because they did not require a major philosophical change and could provide a coping strategy for a particular activating event, but not for a wide range of negative situations. Also, the reattribution, reframing, or changing of the automatic thought might be inconsistent with reality. That is, clients' perceptions and inferences about reality could be accurate. Table 6.3 identifies the interventions for each type of hypothesized mediating cognition in the case of Serge, the angry middle school child mentioned earlier.

The first three cognitive interventions, reframing, reattribution, and challenging the automatic thoughts, are labeled as inelegant. In each of these, the cognitive intervention attempts to change Serge's thinking to believe that the teacher is not as negative toward Serge as he believes. The reframing attributes positive motives to the teacher' actions. The reattribution presents the problem as temporary, and challenging the automatic thought gets him to reevaluate whether the teacher behaves as negatively toward him as he thinks. Each of these interventions assumes that Serge has overestimated the teacher's dislike of him. Each could work if Serge had overestimated the teacher's dislike of him. However, what if Serge is correct? Suppose the teacher does feels prejudiced against him because of his dress, his speech, his ethnic heritage, his taste in music, or for any other reason? These solutions could invalidate Serge's perception and will fail to provide him with a coping strategy for the continuing disapproval from the teacher.

The social problem-solving intervention helps Serge achieve the practical solution, and we know this will result in less emotional disturbance because Serge could entertain the idea that the "A" can change. However, the teacher might be so negative toward Serge that no actions could be successful. REBT almost always uses the elegant strategy. After Serge accepts that the teacher might never like him, the REBT hypothesis is that

Serge will do even better problem-solving if he is less upset. He will also be able to cope if the alternative solutions fail.

If Serge has overestimated the teacher's dislike of him, the elegant solution will work. And according to REBT and Figure 6.1, a change in the core irrational beliefs will result in changing his perceptions, attributions, and automatic thoughts if they are in fact incorrect. It can also result in improved problem-solving skills.

REBT does not predict that the inelegant cognitive interventions will not work. Rather, Ellis believed that they are not philosophical; they do not provide coping strategies across a wide range of stimuli. They could be incorrect and fail to acknowledge clients' negative reality, and thereby fail to provide clients with a coping strategy to their negative reality. REBT acknowledges that all clients might not achieve the philosophical solution, and advocates that the inelegant interventions be used in such cases (DiGiuseppe et al., 2014; Ellis, 1977, 1994, 2003b).

The Three Insights

During psychotherapy, psychotherapists continually work at helping clients develop three insights that will improve their adjustment (DiGiuseppe et al., 2014; Dryden et al., 2010; Ellis & Dryden, 1987).

Insight 1. Past or present activating events do not cause one's disturbance. It is the beliefs one has about them that lead to disturbance.

Insight 2. Regardless of how one learned to think what one thinks, and regardless of how compelling these beliefs have been, one continues to believe in them now because of one's own reindoctrination, rehearsal, or acceptance of these beliefs.

Insight 3. Insight alone is usually not sufficient to change one's over-rehearsed irrational thinking. People usually change irrational dysfunctional thinking through repeated, effortful attempts to challenge these beliefs, construct new ones, and rehearse these new rational beliefs.

The 13 Steps of REBT

Dryden, DiGiuseppe, and Neenan (2010) identified 13 steps that normally occur in a REBT psychotherapy session. They recommended that psychotherapists new to the system learn and follow these steps to avoid mistakes and ensure they perform all the crucial aspects of the model. Some trainees keep a checklist to remind them of the steps and to guide them through a session. The following list presents the 13 steps in a session note format that can be copied from this book and used to record the specific information revealed at each step. All the steps apply to the treatment of children and adolescents, even if the techniques used to accomplish the steps may differ across age groups.

The 13 Steps of Rational Emotive Behavior Therapy in Session Note Format, REBT Session Note, and Guide

Step 1: Ask client for the problem.
Step 2: Define and agree on the goals of therapy.
Step 3: Assess the emotional and behavioral "C."
Step 4: Assess the "A."
Step 5: Assess the existence of any secondary emotional problems.
Step 6: Teach the B–C connection.
Step 7: Assess the irrational beliefs.
Step 8: Connect the irrational beliefs to the disturbed emotions, and connect the rational beliefs to the nondisturbed emotion.
Step 9: Dispute irrational beliefs: Circle all that you have done: logical, empirical, heuristic, design new rational alternative beliefs, didactic, Socratic, metaphorical, and humorous.
Step 10: Prepare your clients to deepen their conviction in the rational belief.
Step 11: Encourage your client to put new learning into practice with homework.
Step 12: Check homework assignments.
Step 13: Facilitate the working through process.

The first step is to ask clients what problems they want to discuss in the session. Sometimes, clients present problems that are unrelated to topics discussed in previous sessions, but mostly they present examples of the primary referral problem. The second step is to agree on the goal of the session. Clients may present entirely new issues unrelated to the issues discussed in previous sessions; psychotherapists might wish to continue with ongoing topics before switching to a new topic. As a result, they might not agree on what to cover in the session and, before continuing, agreement is needed. Also, clients often see the goal as changing the A and psychotherapists see it as changing the C. Because REBT recommends working on emotional problems first, the agreement on the goals aspect of the therapeutic alliance may break down. A consensus on what problem to tackle is crucial for the session to continue. Steps 3, 4, and 5 involve assessing the C, assessing the A, and assessing for secondary emotional disturbance, respectively. At Step 6, the psychotherapist teaches the client the B–C connection (see Vernon, 1998a, 1998b, 1998c, 2007 for techniques). Step 7 involves assessing a client's irrational beliefs. Remember that irrational beliefs are tacit, unconscious, schematic cognitions. They are not experienced in the stream of consciousness, although they are available to our consciousness. Most psychotherapists ask clients, "What were you thinking when you got upset?" Such questions are likely to elicit automatic thoughts, not irrational beliefs. DiGiuseppe et al. (2014) suggest that there are two primary strategies to assess irrational beliefs. The first is "inference chaining." Automatic thoughts are inferences that people draw from the

perceptions they make, and which they are prepared to make by the core schema or irrational beliefs they hold. Follow the logic of the inferences and one can uncover the core irrational belief. Inference chaining involves a series of follow-up questions to the automatic thoughts. These questions ask clients to hypothesize that their automatic thought was true. If it were true, what would happen next, or what would it mean to them? Clients usually respond with other automatic thoughts. The psychotherapist continues with the same type of question until an irrational belief, a "must," an awfulizing statement, an "I can't stand it," or a global evaluation is uncovered. Inference chains will keep clients emotionally aroused, because you are getting closer to their real core issue. Despite the increase in emotional arousal, clients feel relieved to uncover their core beliefs; and this usually provides a bonding experience between the psychotherapist and client.

The second primary strategy is based on the awareness that not all clients are capable of putting their irrational beliefs into language because as tacit, schematic cognitions they might not be stored in verbal memory. REBT (DiGiuseppe et al., 2014) suggested that all psychotherapists develop hypotheses about their clients' irrational beliefs. Rather than let clients struggle to try and become aware of their core irrational beliefs, psychotherapists can offer hypotheses to clients. To do this effectively, psychotherapists should (a) be sure to use suppositional language, (b) ask the client for feedback on the correctness of the hypotheses, (c) be prepared to be wrong, (d) revise the hypotheses based on the responses of the client.

The next steps in the sequence link the clients' irrational beliefs with the clients' emotional disturbance (Step 8). This step requires some care because children often have difficulty distinguishing between thoughts and feelings (Gotterbarn, 1990). Next, the psychotherapists begin disputing the irrational beliefs (Step 9). Challenging irrational beliefs is the most difficult task in REBT. A detailed explanation of the disputing process was created by dissecting many hours of Ellis's videotapes doing therapy (DiGiuseppe et al., 2014). One can dispute an irrational belief by challenging its logic, by testing its empirical accuracy, and by evaluating the functionality of the consequences that follow from holding it. Also, one needs to propose an alternative rational idea, and challenge it with the same arguments to assess whether it fares any better. In addition to adjusting the type of argument, REBT suggests that psychotherapists vary the rhetorical style of their disputing (DiGiuseppe et al., 2014). One can use didactic (direct teaching) strategies, Socratic strategies, metaphors, or humor. Kopec, Beal, and DiGiuseppe (1994) have created a grid with each cell representing a type of argument and a type of rhetorical style. They recommend that psychotherapists generate the disputing statements for each cell in the grid before each therapy session. Their data suggest that this activity increases trainees' self-efficacy in disputing. To better learn disputing techniques, the reader can try this activity for several weeks across several clients. Another important component

of disputing is the use of imagery. Psychotherapists and clients can construct scenes of the client approaching the activating event and rehearsing the new rational coping statement, experiencing adaptive emotions, and behaving appropriately.

Step 10 in the model involves deepening clients' conviction in their rational beliefs. This is accomplished through continued disputing, and also by defining how they would behave differently if they actually held the new rational belief (Step 11), and agreeing to actual homework between sessions to achieve their goals (Step 12). Although REBT uses the term homework with adults, it is best to use a term like practice or rehearsal for school-age clients, because homework is something they naturally resist. Rehearsal assignments could include having them complete REBT homework sheets that guide clients through disputing an irrational belief, the rehearsing of imagery, or engaging in a behavioral activity. Step 13, the final, is to review other examples of activating events the client has been upset about to promote generalization.

Individual Psychotherapy with Children and Adolescents

Early in his career, Ellis adapted REBT to children (Ellis, Wolfe, & Moseley, 1966) in the Living School, an educational program within the Institute. To many people's surprise, REBT can be used with children from as early as age 5, with a variety of emotional problems. Techniques differ for children between the ages of 5 and 11, and adolescents 12 to 18 years old. The most common objection to using such a cognitively oriented therapy with children and adolescents is that children are not cognitively mature enough to engage in this type of discourse. Developmental considerations are important. Several authors have independently suggested (Bernard & Joyce, 1993; DiGiuseppe & Bernard, 2006; Grave & Blissett, 2004; Vernon, 1998a) that children who have reached Piaget's (1963) concrete operations stage can benefit from disputing. Research (Casey & Berman, 1985) has confirmed that cognitive restructuring interventions are more efficacious for children more than 8 years old than under age 8, the approximate age when children enter this stage. Children who have not yet reached the concrete operations phase (those less than 8 years old) will have difficulty with the logic of disputing and with thinking about their thinking. For these children, psychotherapists are recommended to use treatments that focus on concrete skills, such as problem-solving (Nezu, Maguth Nezu, & D'Zurilla, 2013) and rehearsing rational coping statements (Meichenbaum, 1993).

Children are referred because they are disturbing, not because they are disturbed. As a result, most children attend therapy against their will. As a result, children often have not yet decided that they want to change. Therefore, discussing the goals and tasks of therapy is more critical to the establishment of a therapeutic alliance with children than with adults. It is important to consider the concepts of stages of change and processes of change outlined by Norcross et al. (2011). They propose that people pass through a series

of stages of attitudes about change. These include the precontemplative stage, where individuals do not want to change; the contemplative stage, where they are thinking they might change; the action stage, where people try to change; and the maintenance stage, where people consolidate gains and attempt to keep the new behaviors. The stages of change model proposed that the type of therapy needs to match clients' stage of change. REBT is an action-oriented therapy, designed for people in the action stage of change. Because most children and adolescents arrive in the precontemplative stage, the psychotherapists must establish the agreement on the goals and tasks of therapy to build the therapeutic alliance, before using such an active approach.

REBT (DiGiuseppe & Bernard, 2006; DiGiuseppe & Jilton, 1996) recognizing the importance of establishing the therapeutic alliance in children and adolescents or adults who arrive in therapy in the precontemplative stage, especially agreement on the goals and tasks of therapy. Identifying and challenging one's irrational beliefs only makes sense if one holds some prerequisite beliefs. The elements of this motivational syllogism are as follows: (1) my present emotion is dysfunctional; (2) there is an alternative acceptable emotional script for this type of activating event; (3) it is better for me to give up the dysfunction emotion and work toward feeling the alternative one; (4) my beliefs cause my emotions; therefore, (5) I will work at changing my beliefs to change my emotions. Establishing all these beliefs will help motivate a child or adolescent to engage in the REBT process. This model facilitates agreement on the goals of therapy and moving clients to the action stage of change. Psychotherapists need to assess each child's and adolescent's stage of change and agreement on the goals of therapy before proceeding with any REBT interventions. If the child or adolescent has not reached the action stage and does not desire to change, techniques outlined by DiGiuseppe and Jilton (1996), or other similar techniques like motivational interviewing (Miller & Rollnick, 2002) could be used to accomplish this task.

The models proposed by DiGiuseppe and Jilton (1996) involve asking clients to assess the consequences of their emotional and behavioral responses in a Socratic fashion. This helps them identify the negative consequences for their emotional disturbance and behavior. Next, the psychotherapists present alternative emotional reactions that are culturally acceptable to each client. Because people learn emotional scripts from their families, and learn that some emotional scripts are acceptable to their cultural group, it is possible that disturbed children or adolescents have not changed because they cannot conceptualize an acceptable emotional script to experience in place of the disturbed emotion. Psychotherapists need to explore with the client alternative emotional reactions that are culturally acceptable. Next, psychotherapists need to help clients make the connection that the alternative script is more advantageous to the client.

Individual Psychotherapy with Children

A typical therapy session with a preadolescent child might involve some variations on the 13-step model and could be organized as follows:

1. Because children do not always remember what has happened during the week, the session may start by meeting with the parents and child to talk about the progress of the past week.
2. Together, the psychotherapist and child plan the session agenda.
3. The psychotherapist reviews the homework assignment from the past week, sets session goals, discusses activities to be used to reach session goals, and discusses the consequences of modifying disturbed behaviors and emotions.
4. The client is helped to generate alternate emotional scripts that include new ways to feel and act.
5. Next the psychotherapist will teach the B–C and explore the beliefs that lead to the disturbed emotion.
6. The client and psychotherapist challenge the irrational beliefs and explore rational alternative beliefs.
7. The client and psychotherapist agree on homework assignment for the coming week and review the homework assignment with the parents (DiGiuseppe, 1989, 1994).

Psychotherapists explain and demonstrate how thoughts can cause feelings, and that certain thoughts (irrational beliefs) produce disturbed emotions, whereas other thoughts (rational beliefs) lead to nondisturbed emotions. Some children could have difficulty distinguishing between disturbed and nondisturbed emotions, and therefore, the psychotherapist might need to teach them to identify and label various emotions and then to be able to distinguish between those that are helpful and those that are hurtful. Further, the psychotherapist teaches that thoughts can be changed to produce nondisturbed feelings. The psychotherapist helps the child practice distinguishing between disturbed and nondisturbed cognitions and emotions. Additionally, the child practices disputing irrational beliefs and replacing them with more rational thoughts. Specific techniques used to help the client practice these skills include modeling, role-playing, and imagery, as well as homework involving the parents.

REBT with preadolescent children is concrete and usually involves activities and hands-on materials that teach the concepts. Many of these activities are presented in Bernard and Joyce (1993) and Vernon (1998a, 1998b, 1998c). With younger children, not yet capable of disputing, the psychotherapist teaches them to use rational self-talk

to deal with the problem situation whenever it arises. The child practices rational coping statements (DiGiuseppe, 1977) based on Meichenbaum's (1993) self-instructional guidelines (see Ellis, & Wilde, 2002, for case examples).

The REBT approach developed adapted tools for teaching children its principles, based on play and metaphors. The therapeutic or rational stories for children (Waters, 1980), and the RETMAN character and its comics (Merriefield and Merriefield, 1979) were the first developed. The RETMAN character was recently developed into rational stories (David, 2010), cartoons (David, 2013), and a robotic system (David & David, 2013; see at www.retman.ro). The book of therapeutic stories "Retmagic and the wonderful adventures of RETMAN" presents the RETMAN character having his own story (e.g., he is coming from a planet called Rationalia, in the happiness galaxy) and adventures for teaching earth inhabitants the secrets of the good mind. Each of the irrational processes is represented by a character. The cartoons RETMAN and Retmagic are presenting the adventures of the character in five episodes, first dedicated to the story of RETMAN and the other four to managing a dysfunctional emotion (depression, anxiety, anger, and guilt). The RETMAN robotic system (roboRETMAN) incorporates the mechatronic device based on an action figure of the RETMAN character, and is offering children with rational statements in the form of the "psychological pills" (i.e., "It is bad but not catastrophic to feel this way"; David & David, 2013). The system is currently developed to incorporate online gaming components based on the RETMAN's adventures.

Individual Psychotherapy with Adolescents

Developmentally, adolescents are concerned with forming their identities. They can often be oppositional and refuse to heed the advice of people from a different generation. They are somewhat egocentric and believe that their problems are unique to themselves or their generation. They are also often sent to therapy against their will, and arrive in the precontemplative stage of change. With adolescents, it is particularly important to ensure that the psychotherapist has agreement on the goals and tasks of therapy, and to explain to the clients how the tasks will improve their current situation. Therefore, we recommend psychotherapists go through the steps of the motivational syllogism before the discussion of each new problem and before the use of any intervention.

Compared to working with children, the psychotherapist can focus more on providing insight, and can expect to engage in both elegant and inelegant disputing. It is important, though, not to assume that the adolescent will necessarily follow a logical argument and therefore can engage in disputing irrational beliefs. Although adolescents have achieved greater cognitive development, some research suggests that REBT is more effective with preadolescent children. Adolescents are developmentally mature enough that the psychotherapist can use all the strategies and cognitions that have been

proposed with adults. However, adolescents know it all. Therefore, they appear to do better with Socratic disputing than with didactic interventions. Clinical experience suggests they respond best to functional disputes of their irrational beliefs rather than logical ones. Adolescents, as a whole, are idealistic. They often believe that what is good or righteous must be. Empirical disputes aimed at demonstrating that reality is not as it should be also seem not as helpful. Again, functional disputes appear to work best. Time will eventually teach adolescents to distinguish between the real and ideal world. Also, adolescents overvalue peer acceptance. It is helpful to have an adolescent recall the rational beliefs that have been endorsed by a peer, or to search the lyrics of popular songs for rational messages. These techniques increase the likelihood the idea will be adopted.

Group Procedures with Children and Adolescents

Ellis long advocated Rational Emotive Behavior Group Therapy (REBGT). The group process, or focusing on how group members relate to each other, is not the primary focus of REBGT. However, conflicts between members that develop are important topics for discussion because they often reflect the child's ability to relate to peers, which is often a reason for referral. Group therapy is usually recommended for financial reasons. Administrators like psychotherapists to provide group therapy because more clients are treated for the same hour of psychotherapist time. It is important that psychotherapists use group therapy for clinical rather than economic reasons. REBGT appears most helpful for people with social difficulties. The group forces them to confront their social fears and the exposure to others helps build social skills. It is also helpful to place clients in groups after a brief period of individual therapy. The group experiences help them overlearn the skills of controlling their emotions, after they have gotten a good start from individual therapy. Clinical experience suggests that children with disruptive behavior problems do poorly in groups. They are primarily reinforced for their disruptive behavior by peer attention that the psychotherapist cannot control. Therefore, the group can become uncontrollable. Younger children with disruptive behavior problems ages 7 years and below can be treated in groups if the psychotherapist has a reinforcement system for cooperation and has access to rewards that are of interest to that age level.

Two formats can be used in REBGT. With the open-ended format, group members take turns presenting a problem on which they want to receive help. Psychotherapists and group members help that client solve the problem using REBT principles. As the group continues, clients learn from the problems they present, from the advice and comments of the psychotherapist and the other group members, and from observing how the other group members are helped. With this format, psychotherapists need to be aware of the clock to ensure that one client does not take too much time in any session, and that all clients get equal opportunity to present their problems. Clients tend to offer

more practical solutions than emotional solutions in the group. A discussion of philosophical solutions is unlikely to occur unless psychotherapists steer the discussions in that direction.

A second format is the homogeneous group. Here all the group members have a similar problem. Psychotherapists can present a series of discussions and exercises related to the problem. In each session, the psychotherapist leads the members in a discussion and/or exercises, and makes sure that all members participate and learn to apply the new skills to their individualized problem.

With adults, REBGT has been practiced with members with homogeneous and heterogeneous problems. However, with children it appears best to group the members by the presenting problem and by the child's age. Mixing children with too many different problems may make it difficult for them to focus on issues that do not relate to them. REBGT employs a psychoeducational model. Having children who differ in age by more than 3 years also presents too great a range of developmental skills for the psychotherapist to address all the members' issues and to keep the attention of all the members. Much of the material that has been developed for classroom applications of REBT can and is used by psychotherapists in REBGT.

Classroom and Educational Applications

From its inception, Ellis considered REBT to be a psychoeducational method that could be taught to people in workshops, classrooms, and groups (Bernard & DiGiuseppe, 1990). From 1971 to 1975, the Institute for Advanced Study in Rational Psychotherapy ran an elementary school in the building with a curriculum that taught rational thinking as a preventive mental health program along with the standard academic subjects. During this time, the institute staff developed exercises and classroom activities to teach various thinking skills. These activities resulted in an initially syllabus (Knaus, 1974), which included well-specified activities that teachers, guidance counselors, or psychotherapists could use to educate children in the ABCs. These original materials served as models for further generations of such manuals including the more detailed classroom/group manuals by Vernon (1998a, 1998b, 1998c). These syllabi focus on specific emotional problems children have and lessons that teach the following skills: (a) developing critical thinking skills; (b) distinguishing between thoughts and feelings; (c) distinguishing between opinions, facts, and hypotheses; (d) linking thoughts and feelings, the B–C connection; (e) identifying ideas that lead to emotional upset; (f) distinguishing between rational and irrational beliefs; (g) challenging irrational beliefs; and (h) specific modules on self-worth versus self-esteem, low frustration tolerance, demandingness, and catastrophizing (Vernon, 2007). Although these materials were designed for educational purposes, they make excellent activities to use in groups.

The most comprehensive educational REBT program is Bernard's *You Can Do It*. This multimedia presentation includes an excellent, professionally produced video that

focuses on the cognitive skills and attitudes necessary to succeed academically, and the irrational beliefs that block achievement. In addition to these videos, the *You Can Do It* series includes student workbooks, teachers, manuals to guide discussions, and accompanying visual overheads. All the materials are designed with appealing cartoon characters.

Bernard (1990) also developed an REBT stress management program group for teachers. The program includes a teachers' irrational belief scale that can be used as a pretest to identify each teacher's irrational beliefs. The scale has been shown to discriminate between teachers who are on disability because of emotional stress and well-functioning teachers. His REBT stress management syllabus helps the participants learn the ABCs and identify the beliefs that led to their job stress. It also teaches strategies to dispute irrational beliefs, and how to develop rational alternative beliefs. Bora, Vernon, and Trip (2013) tested the effectiveness of a REBT program for reducing teachers' irrationality, dysfunctional emotions, and behaviors. Results showed a decrease in measures of these constructs, and the results were maintained at 4-month follow-up.

Bernard and DiGiuseppe (1993) adapted REBT to consultation activities in the school. Most models of psychological consultation assume that the consultant may have some expert knowledge that the consultee can use. By building a collaborative relationship and problem-solving set, the consultant is able to suggest information or strategies that the consultee is free to accept or reject. Most models of organizational, educational, behavioral, and instructional consultation assume that the consultee only needs new information. Like mental health consultation, REBT theory suggests that teachers, parents, principals, and administrators can be blocked from seeing or implementing solutions to problems by their own emotional disturbance. Bernard and DiGiuseppe (1993) suggested that consultants evaluate the consultees' emotional responses to the problems and their thinking. Often consultees become stuck because they rigidly adhere to ideas about how things must be done and respond emotionally to problems instead of seeking solutions. The REBT-oriented consultant will look for such reactions in consultees and Socratically explore the consultees' emotional reactions and rigid thinking. The first task of the consultant is to help consultees become aware of their emotional reactions and have them agree to discuss their feelings and thinking. Bernard and DiGiuseppe (1993) applied this model to working with teachers, parents, and administrators around instructional and organizational issues.

Parental and Family Involvement in Therapy

Parents become the focus in REBT sessions treating children in several ways (see Bernard, 1995, 2006; DiGiuseppe & Kelter, 2006; Doyle & Terjesen, 2006; Joyce, 2006). First, they can be the primary targets of intervention to overcome their own emotional disturbance that interferes with their parenting. Research has shown that parents' emotional disturbance is the primary reason adults fail to engage in correct

parenting practices (Dix, 1991) and fail to benefit from behavioral parent training programs (Dadds & McHugh, 1992). Although behavioral parent training appears to be the most successful intervention with children with externalized disorders (Kazdin & Weisz, 2010), parents are unlikely to display good parent skills if their emotional disturbance about their child's behavior interferes (David, David, & DiGiuseppe, 2014). DiGiuseppe (1988; DiGiuseppe & Kelter, 2006) proposed a sequential family therapy model for the treatment of externalized disordered children who are unwilling to participate in individual therapy (see list below). It focuses on the following steps:

1. A thorough assessment of the child's pathology, a behavioral analysis of the eliciting stimuli and reinforcers, consequences, and family functioning.
2. Forming a therapeutic alliance with the parents.
3. Choosing a target behavior and consequences collaboratively with the parents.
4. Assessing parents' ability to carry out the interventions, including their emotional reactions and irrational beliefs.
5. Changing parents' irrational beliefs and emotions that would interfere with performing the new parenting strategies.
6. Have parents predict what resistance they expect to occur to their new parenting strategies from the identified patient or other family members, and generate solutions to confront these attempts at resistance.
7. Assess the parents' ability to follow the strategies they choose to handle the resistance, again focusing on their emotions and irrational beliefs.
8. Intervening with parents again at changing the irrational beliefs and schemata that would prevent them from handling the resistance.
9. Continuing to assess the children's progress and the parents' compliance with the behavioral skills, and modify behavior treatment plan as needed.
10. Start individual psychotherapy with the child to internalize gains made by the behavioral intervention.

Sequence of Family Therapy for Treatment of Externalized Disorders

Stage 1: Assessment. Assess (a) What is the nature of psychopathology? (b) What is the developmental level of functioning, and the discriminative stimulus that elicit the problems and its reinforcers? (c) What is the structure of the family? (d) What are the roles of individual family members? (e) Who will resist? (f) What are the emotions, skills, and cognitions of each member?

Stage 2: Engaging parents in the therapeutic alliance. If one parent is resistant to change, use motivational interviewing or problem-solving with the motivated parent to engage the resistant parent.

Stage 3: Behavioral intervention. Choose a target behavior and reinforcers.

Stage 4: Assessing parents' ability to carry out agreed intervention. Assess the parents' emotions and cognitions that may stop them from carrying out the agreed-on intervention. Possible parental interfering emotions: guilt, anger, anxiety, discomfort. Parents' irrational beliefs: demandingness, catastrophizing, frustration intolerance, self-downing, projected frustration intolerance, condemnation of the child.

Stage 5: Therapy on the parents. Cognitive restructuring of the parents' irrational beliefs. Use all the techniques that one would in adult REBT to focus on the emotions and cognitions identified in the previous stage.

Stage 6: Predict resistance. What do the parents believe the child or others will do to sabotage their efforts? Problem-solve how they can respond to those attempts at sabotage. This will help them to do it on their own after termination.

Stage 7: Assessment of the parents' ability to follow intervention. Imagine themselves following through. What emotions and beliefs will they have about this new action? What do they believe their emotional reactions will be to these interventions? Assess emotions and cognitions that will get in their way of following through on the intervention chosen to counteract the sabotage.

Stage 8: Intervention with parents. Dispute the irrational beliefs that they will experience and that could encourage them to give into the resistance.

Stage 9: How will the child respond to the new action? (a) Repeat assessment, (b) redesign interventions through collaborative problem-solving, (c) continue to assess parents' ability to carry out the new interventions, (d) continue to use cognitive restructuring to help them follow through on the planned interventions.

Stage 10: Individual therapy for the child or adolescent. At the beginning of each session, assess the progress the child and parents have made. If parents have followed their interventions, remain at this stage. If they have not, return to Stage 8. Use the motivational syllogism to help the child internalize the desirability of change and cooperation with the psychotherapists. Use all REBT and CBT methods to reduce the undesirable target behaviors and support the desired positive changes.

In DiGiuseppe's (1988; DiGiuseppe & Kelter, 2006) model, changing the parents' irrational cognitions and emotional disturbance is done to get the parents to adopt more effective parenting skills, which is necessary to accomplish the primary goal of changing the child's symptomatic behavior. However, the parents' disturbance is a crucial target of the interventions.

Huber and Baruth (1989) integrated REBT with family systems therapy. They maintain that family systems theories require some individual psychological variables to explain how the family members maintain dysfunctional homeostasis. Huber and

Baruth (1989) believe that irrational beliefs and their resulting emotional arousal lead to avoidance of change and thereby maintain the homeostasis. This model hypothesizes that family members share common irrational beliefs, such as rigid rules about the roles family members must play, beliefs that certain topics must not be discussed, beliefs that certain or all family members must behave in certain ways, or rules about how family members must react to the outside world. Many family systems psychotherapists present similar cognitive constructs, which they call family myths. Huber and Baruth (1989) believe that acknowledging the role of shared family cognitions and integrating systems therapy with cognitive interventions such as REBT can provide psychotherapists with a set of skills to accomplish the cognitive elements in family disturbance. Huber and Baruth (1989) see families as a unit and work at identifying the family structure, assessing the irrational family beliefs or myths that maintain the dysfunctional family structure. They then help all family members challenge and replace the irrational family myths, and conceptualize new ways of behavior based on alternative rational family beliefs.

Parents can play an essential role in treatment even when the focus of psychotherapy is changing the child. Currently, group parenting programs are recommended as treatment of choice for child conduct disorders (see NICE guidelines) and their efficacy is well documented as stand-alone treatment for child psychopathology (Lundahl, Risser, & Lovejoy, 2006). The assumption is that parents can function as agents of change for promoting their child's mental health and reducing psychopathology by learning how to use efficient and consistent parenting practices. Several REBT parenting program curricula have appeared to-date (Clark, 1996; Gavita, 2011; Joyce, 1995) for promoting child mental health, with the Rational Positive Parenting program receiving recently most empirical support (Gavita, DiGiuseppe, & David, 2013). The Rational Positive Parenting (RPP) program uses a group format for teaching parents effective strategies for dealing with child disruptive behaviors (using praise, rewards, point charts, family rules, negative consequences, time-out), while building own/child unconditional acceptance and frustration tolerance. The standard RPP program has 10 sessions of 90 minutes and its first two sessions are dedicated toward building parent emotion-regulation skills through rational thinking, and focusing on improving parenting practices only afterward. Variations of the program have been developed and tested (David, 2014; Gavita & Călin, 2013; Gavita, David, Bujoreanu, Tiba, & Ionuţiu, 2012) in terms of standard and short format, group format, or self-help bibliotherapy (including "psychological pills" for parents; Gavita et al., 2013) or online format (including attention bias modification procedures; David, in press), and were adapted for addressing externalizing or internalizing symptoms in children and adolescents.

In individual psychotherapy of the child, parents are often unaware of the issues discussed by the psychotherapist and child. Parents often want to be involved in their children's psychotherapy because of their natural concern for their children's well-being.

If the child agrees, if the problem does not necessarily involve a family matter the child would feel inhibited to discuss in front of the parents, and if the parents are willing, parents can play a helpful role in the child's individual psychotherapy. DiGiuseppe and Bernard (2006) recommended four ways that parents can become involved to improve the effectiveness of individual psychotherapy. First, children can be given the homework assignment of describing the important points of a session to their parents, such as the B–C connection or disputes to irrational beliefs or the rational coping statements they will use when they become upset. This technique provides children with opportunities to rehearse the principle psychotherapists want to teach, and allows the parents to feel involved with their children's treatment.

Second, parents can join the psychotherapy session. When problematic activating events or emotional upsets occur between sessions, parents usually attempt to help their children and provide advice. Sometimes parents' comments are inconsistent with the psychotherapists' goals, or they reinforce their children's irrational thinking or are just not helpful. If parents have been present during the sessions, they can remind their children of the rational coping statements that were provided in the session or they can use the principles of REBT that they learned in session to guide their responses to their children when the child experiences problems. Again, parents who participate in this way feel good about being part of the solution and report learning how to talk to their children in ways that are helpful to their children. Some parents even report that it has helped them with their own emotional problems.

Third, parents can provide information that children often forget. Weekly psychotherapy sessions were designed for adults. Children often fail to remember significant events that happen between sessions, thus denying psychotherapists important information on problems children have had between sessions. When parents are present, they often remind the children of successful coping experiences that they have had that psychotherapists can reinforce. The parents also report important activating events that children do not handle well that could be the focus of the session.

Fourth, psychotherapists can design homework assignments that include the parents. For example, children with social anxieties who withdraw when they are teased need to learn disputes to their fear-provoking beliefs and to learn new rational coping statements to verbal attacks by peers. Often psychotherapists can role-play the verbal attacks in the session and the children learn to rehearse their disputes and coping statements. Psychotherapists can enlist the parents to role-play their children's tormentors between sessions. The parent can call out a barb to the child and the child will rehearse the new cognitions as well as new social skills. Here the parents prompt rehearsal of a new response and can coach the child because of what they have learned in the session. Whenever and however possible, it is thus recommended to involve parents in the child's treatment.

The Efficacy of REBT

The American Psychological Association (2012) passed a resolution affirming that the effectiveness of psychotherapy is widely accepted to be significant and large; and that the differences in outcome across different forms of psychotherapy are not as "pronounced" as has been expected. Research in psychotherapy has evolved considerably in the past four decades. Presently, few researchers are interested in the horse race of determining which psychotherapy is the most efficacious (see Campbell, Norcross, Vasquez, & Kaslow, 2013). This resolution reported on the effectiveness and professional accepted forms of psychotherapy. Thus it is still important to document the effectiveness and efficacy of each type of psychotherapy.

Before committing oneself to practicing a form of psychotherapy, a professional had better review the outcome literature to evaluate its efficacy. This should be true of REBT because Ellis has placed such a value on the scientific method.

Smith and Glass's (1977) original meta-analytic review of psychotherapy outcome studies concluded that RET (as it was called then) was the second most effective psychotherapy, after systematic desensitization. Successive meta-analytic reviews failed to distinguish between narrowly defined types of therapies and categorized therapies into broader classes of cognitive-behavioral, behavioral, and psychodynamic. REBT studies have been categorized with CBT. Despite its early showing by Smith and Glass (1977), REBT has maintained a reputation of having insufficient empirical support. This view probably evolved because Ellis's career has focused on theory and practice rather than research.

REBT outcome research includes 16 previous reviews (DiGiuseppe, Miller, & Trexler, 1977; Engels, Garnefski, & Diekstra, 1993; Esposito, 2009; Ford, 2009; Gossette & O'Brien, 1992, 1993; Haaga & Davison, 1989; Hajzler & Bernard, 1990; Jorm, 1989; Lyons & Woods, 1991; Mahoney, 1974; McGovern & Silverman, 1984; Oei, Hansen, & Miller, 1993; Polder, 1986; Silverman, McCarthy, & McGovern, 1992; Zettle & Hayes, 1980). Most of these are narrative reviews; five are meta-analyses (i.e., Engels et al., 1993; Esposito, 2009; Ford, 2009; Lyons & Woods, 1991; Polder, 1986). Most have included studies of adults and children, others have focused only on adults (Gossette & O'Brien, 1992; Zettle & Hayes, 1980), and two have focused only on research with children and adolescents (Gossette & O'Brien, 1993; Hajzler & Bernard, 1990). Most reviewers have included published reviewed articles and unpublished dissertations. Others have included a majority of unpublished dissertations in their review (Gossette & O'Brien, 1992, 1993). Most have been favorable, although some others have been critical. Table 6.4 lists the reviews alphabetically by author, the year published, the range of years of the studies included, the populations reviewed, and their general conclusions.

Each review employed a different selection criterion. More than 300 studies are mentioned in these 16 reviews. However, the reviews rarely included the same studies.

Table 6.4 Reviews of the REBT Outcome Literature

Authors	Year Published	Range of Years Studied	Number of Studies	Focus	Conclusions
DiGiuseppe, Miller, and Trexler	1977	1970–1977	26	Published and unpublished studies of children and adults.	Support for RET, "… appear (s) generally positive, 7 promising, but far from conclusive," p. 70.
Engles, Garnefski, and Diekstra	1993	1970–1988	32	Published and unpublished studies of children and adults.	"RET on the whole was effective compared with placebo and no treatment. Its effects were maintained over time, and it produced a delayed treatment effect with regard to behavioral outcome criteria," p. 1088.
Esposito	2009	1972–2008	72 (39 dissertations and 33 published articles)	Published and unpublished studies of children.	"The largest effect sizes were found for ratings by independent observers, followed by self-report, teacher report, therapist report, and parent report, although the differences were not significant. A moderate positive effect size was found for the overall comparison of REBT to control groups. A small positive effect size was found for the overall comparison of REBT to alternative groups."
Ford	2009	1990–2008	191	Published and unpublished studies of children and adults.	Results indicated that mean treatment effects were roughly equivalent (pre-1990: within REBT = 0.89, REBT vs. control = 0.56, REBT versus alternative treatment = 0.23; post-1990: within REBT = 0.89, REBT versus control = 0.57, REBT versus alternative treatment = –0.04) and that mean study methodological quality ratings were consistent across time periods (pre-1990 = 5.91; post-1990 = 5.84) and not correlated with effect size.
Gonzalez, Nelson, Gutkin, Saunders, Galloway, and Shwery	2004	1972–2002	19	Published studies of children and adolescents.	"The overall mean weighted effect of REBT was positive and significant." "Analyses revealed … (a) there was no statistical difference between studies identified low or high in internal validity; (b) REBT appeared equally effective for children and adolescents presenting with and without identified problems; (c) non-mental health professionals produced REBT effects of greater magnitude than their mental health counterparts; (d) the longer the duration of REBT sessions, the greater the impact, and (e) children benefitted more from REBT than adolescents," p. 222.

(*continued*)

Table 6.4 (*continued*)

Authors	Year Published	Range of Years Studied	Number of Studies	Focus	Conclusions
Gossette and O'Brien	1992	1970–1990	85	Published and unpublished studies of adults.	"RET was effective in 25% of comparisons," p. 9. RET results in "… a decreased score on scales of irrationality … a parallel decrease in self-reported emotional distress. Other measures, noticeably behavior, were insensitive to RET. RET has little or no practical benefit," p. 20.
Gossette and O'Brien	1993	1974–1992	36	Published and unpublished studies of children and adolescents.	RET has little or no practical benefit. The most distinctive outcome of RET is a decrease in the endorsement of irrational beliefs, p. 21. We can conclude that continued use of RET in the classroom is unjustified, in fact, contraindicated, p. 23.
Haaga and Davidson	1989	1970–1987	69	Published and unpublished studies of adults.	
Hajzler and Bernard	1990	1970–1982	45	Published and unpublished studies of children and adolescents.	"… support for the notion that changes in irrationality and changes in other dimension of psychological functioning." "… changes have been maintained at follow-up periods," p. 31.
Jorm	1989	1971–1986	16	Studies of any type of theory that include a measure of trait anxiety or neuroticism.	"While RET and related therapies proved superior in the present meta-analysis (to other therapies), this conclusion is limited by the breadth of studies available," p. 25.
Lyons and Woods	1991	1970–1988	70	Published and unpublished studies of children and adults.	"The results demonstrated that RET is an effective form of therapy. The efficacy was most clearly demonstrated when RET was compared to baseline or other forms of controls. Effect sizes were largest for dependent measures low in reactivity (i.e., low reactivity = behavioral or physiological measures; high reactivity = measures of irrational thinking)," p. 68.
Mahoney	1974	1963–1974	10	Published and unpublished studies of cognitive restructuring and RET.	RET "… has yet to be adequately demonstrated" and "… may be viewed as tentatively promising," p. 182.

McGovern and Silverman	1984	1977–1982	47	Published and unpublished studies of children and adults.	" … there were 31 studies favoring RET. In the remaining studies, the RET treatment groups all showed improvement and in no study was another treatment method significantly better than RET," p. 16.
Oei, Hansen, and Miller	1993	1982–1988	9	Studies designed to assess whether irrational beliefs mediate change in other psychological constructs.	"This review demonstrates that while RET has been demonstrated to be an effective therapeutic intervention for a variety of target problems, there is no evidence to show improvement in RET is due to changing irrational beliefs to rational beliefs," p. 99.
Polder	1986				REBT yielded higher effect sizes than other forms of CBT.
Silverman, McCarthy, and McGovern	1992	1982–1989	89	Published and unpublished studies with children, adolescents, and adults.	" … 49 studies resulted in positive findings for RET." When compared to other treatments, … no other treatments were found to be significantly better than RET.
Trip, Vernon, and McMahon	2007	1970–2006	26	Published studies with children and adolescents.	"Rational Emotive Education had a powerful effect on lessening irrational beliefs and dysfunctional behaviors, plus a moderate effect concerning positive inference making and decreasing negative emotions." … "Effect sizes increased from medium to large when the subjects were children and adolescents compared to young adults."
Zettle and Hayes	1980	1957–1979	20	Published and unpublished studies with college students and adults.	" … the clinical efficacy has yet to be adequately demonstrated," p. 161.

We found only 13 studies were mentioned in 5 reviews; 3 studies were included in 6 reviews; and 124 studies were mentioned in just 1 review. The reviews have very low agreement on which studies they included. Most of the reviews ignored, excluded, or failed to uncover a sizable number of studies from the time period they selected from. The most inclusive reviews were the two by Silverman and colleagues (McGovern & Silverman, 1984; Silverman et al., 1992).

We found more than 70 REBT outcome studies not reported by the reviews. Although some of these were published after the reviews were published, many appeared during the period from which the reviews sampled studies. More than 350 REBT outcome studies have been found. A substantial number of studies exist that compare REBT to no treatment, waiting lists, or placebo controls, and support the efficacy of REBT across a wide range of problems including: social, testing, math, performance, and public speaking anxiety, agoraphobia, neuroticism, stress, depression, anger, teacher burnout, personality disorder, obsessive compulsive disorder, marriage and relationship problems, alcohol abuse, poor dating skills, overweight/obesity, school discipline problems, unassertiveness, Type A behavior, parenting problems, emotional reactions to learning disabilities, school underachievement, sexual fears and dysfunction, and bulimia.

The review of Gonzalez et al. (2004) was more restrictive, selecting only 19 rigorous studies, and concluded that REBT is equally effective for children and adolescents presenting with (45 effect sizes) and without (13 effect sizes) disturbances. Based on 56 effect sizes, a medium weighted effect was obtained for the REBT compared with control groups. Authors coded outcomes for anxiety, disruptive behaviors, irrationality, self-concept, and grade point average, and for all outcomes the improvements following REBT were significant. REBT worked best for reducing anxiety and irrationality and improving grades. Similar medium size effects were obtained when comparing REBT with alternative treatment or with no treatment control groups. Best results were found when applying REBT to elementary school children and high-school adolescents.

Despite the larger number of investigations of REBT, the overwhelming majority of studies compared REBT with a no contact, waiting list, or placebo condition. Few studies compare REBT with a viable, alternative treatment. Although REBT is better than no treatment or placebo treatments for many problems, there is no evidence that it is more efficacious than alternative treatments or that there is one condition for which it is the treatment of choice.

Also, the research has provided little to advance our knowledge concerning the best way to practice REBT. Does the inclusion of imagery, written homework forms, bibliotherapy, or the style of disputation make a difference in the outcome? How many sessions of REBT are necessary for clinical improvement? Researchers have failed to explore which are the critical components of REBT. However, considerable research by Mersch and Emmelkamp (Mersch, Emmelkamp, Bogels, & Van der Sleen, 1989; Mersch, Emmelkamp, & Lipps, 1991; Mersch, Hildebrand, Lavy, Wessel, & van de Hout,

1992) indicates that in vivo exposure exercises are a critical component to REBT with social phobia. Also, no studies have addressed the issues of whether the positive effects of REBT are obtained by changing clients' irrational beliefs before change occurs in other dependent measures (Oei et al., 1993). The meta-analysis by Lyons and Woods (1991) suggested that more psychotherapy sessions produced greater effect size and that more experienced psychotherapists produced larger effect sizes than less experienced psychotherapists. They concluded that dependent measures low in reactivity produced higher effect sizes than measures high in reactivity. These findings are the opposite of those reported by Gossette and O'Brien (1992, 1993). Several reviews indicated that no alternative treatment was more efficacious than REBT.

Generally, psychotherapy research with children and adolescents has lagged behind research with adults (Kazdin & Weisz, 2010). This has also been true of research in REBT. Sixty-nine studies mentioned by the reviewer had been done with children and adolescents. However, the majority of these studies could be considered analogue studies or tests of REBT as a preventive intervention because they focused on using REBT with normal children in groups or in classrooms. Studies of clinically diagnosed children and adolescents are less represented.

The meta-analysis by Trip, Vernon, and McMahon (2007) was focused on effectiveness of the classroom Rational Emotive Education in promoting mental health and reducing subclinical problems. Authors combined results from 26 published studies. Results obtained showed that REE is effective in producing changes in emotional, cognitive, and behavioral outcomes, and is most efficient with reducing irrational beliefs and behavior modification. This review showed an overall medium effect size for REE compared with the baseline, control group and placebo group, and large effect sizes compared to other interventions, like relaxation, self-instructional training, human relationship, or experiential therapies. These effects were maintained at follow-up. Larger effect sizes ($d = .92$) were obtained for longer interventions but no significant differences were obtained between the short- (4 meetings) or long-term ones (17 meetings). Effectiveness of the REE was moderated by the problem presented or by the population, higher effect sizes being obtained for children and adolescents with subclinical problems. In terms of the type of the subclinical problem presented, the REE worked best for academic and anxiety problems (high range) and moderately for behavior problems. Bernard (1990) showed that an REBT program decreased teacher stress. Although more research is needed, these studies suggest that psychologists may find REBT useful in educational settings.

Meta-analytic reviews of psychotherapy with children and adolescents have demonstrated (Weisz, Weiss, Alicke, & Klotz, 1987; see Kazdin & Weisz, 2010, for a review) that behavioral and cognitive therapies produce more change than nonbehavioral or traditional, nondirective, or play therapies. Because REBT shares many similarities with other behavioral and cognitive therapies, there is good reason to suspect that research in

REBT with children and adolescents will continue to support its effectiveness. However, there are many unanswered questions. Is REBT better than other forms of psychotherapy? Is REBT more efficacious than other CBT or behavioral interventions? Is there a problem for which REBT is the treatment of choice? It is important for research to address the effectiveness of specific techniques in REBT with children and adolescents. Do all children benefit from logical disputing, or can rehearsing rational coping skills without disputing be as effective? Although there is some evidence to indicate that children can benefit from REBT written homework forms (Miller & Kassinove, 1978), do all children benefit from the bibliotherapy and written homework sheets frequently used in REBT? REBT has also been shown to be effective with culturally diverse populations (Sapp, 1994, 1996; Sapp & Farrell, 1994; Sapp, Farrell, & Durand, 1995).

The REBT parent training program developed by Joyce (1988) was proved to be effective in improving parents' emotional reactions to their children. Graves (1996) expanded on Joyce's program and demonstrated that the program could reduce stress and improve parenting skills in parents of Down syndrome children.

The efficacy of the Rational Positive Parenting program (Gavita et al., 2013; Gavita, 2011) was recently investigated in rigorous studies, with different formats, for various populations, and its efficacy in addressing child and adolescent externalizing and internalizing problems has been documented. The program in the standard 10 sessions group format was found (David, 2014; Gavita, 2011) to be efficacious in the treatment of child externalizing behavior, compared to wait-list, and producing more generalized and long-lasting results compared to the standard cognitive-behavioral parenting programs. The mechanisms of change of the program were analyzed and found to be both improvements in parental distress and parenting. Moreover, the program was found (Gavita et al., 2012) efficacious in a short, four-session, group format for reducing fostered children and adolescent disruptive behavior.

The short format of RPP was investigated (Gavita & Călin, 2013) also as a self-help format, compared with the RETMAN therapeutic stories (David, 2010) for children in reducing externalizing and internalizing syndromes in elementary school children. Children in the RETMAN therapeutic stories group obtained greater improvement compared to the short RPP program for teacher-reported externalizing syndromes, child-reported anger experienced in school, and irrational demands for fairness. The short RPP program brought higher improvements in turn for the parenting dimensions of laxness and verbosity.

The technology and game-based innovative REBT tools were recently investigated for their effects in helping children become more emotionally resilient. Preliminary positive effects of the RETMAN cartoons and robotic system were documented (David & David, 2013) for helping elementary school children manage their test anxiety. Both the roboRETMAN and the cartoons worked better and children reported more positive effects after playing with the roboRETMAN. This is one of the first studies investigating

efficacy of REBT-based rational statements as emotion-regulation strategies in children when facing dysfunctional emotions and its results are very important for offering insights on the tools can be used for making them accessible.

CONCLUSION

Although REBT was one of the original cognitive behavior therapies, it has changed significantly since it was introduced by Ellis more than 60 years ago. The theory focuses on the role of irrational, dogmatic, and rigid thinking in causing psychopathology. Irrational beliefs are tacit, pervasive, rigid schematic representations of the way the world is and ought to be. These beliefs are both factual and evaluative. Beliefs are irrational when they are rigidly held in the face of evidence that they are logically inconsistent, anti-empirical, and self-defeating. The theory discriminates between adaptive and maladaptive emotions. Its goal is not to eliminate negative emotion, but to replace maladaptive negative emotions with more adaptive negative emotions, and to help people better their lives when they are free of emotional disturbance.

The primary techniques of REBT involve challenging and replacing dysfunctional irrational beliefs. Many logical, empirical, and functional strategies for challenging beliefs are recommended. In addition, REBT employs a wide range of behavioral, imaginal, and emotive exercises to bring about change. The theory stresses the importance of rehearsal of new ways of thinking, and almost any technique that accomplishes this purpose is appropriate.

Although REBT was originally designed for neurotic adults, it has been used with children and adolescents for more than 35 years. It follows a psychoeducational model that allows it to be used in groups, workshops, and classrooms as a preventive procedure. Because of its psychoeducational format, REBT can easily be integrated into educational settings. It can be used in an educational format to teach students, parents, and teachers how to reduce their emotional disturbance and improve their productivity. REBT provides a model for school mental health services including direct service and consultation.

REBT has focused from its beginnings on adapting its tools to children. Thus, many tools have been developed for building child emotional resiliency, among which the therapeutic or rational stories for children (i.e., the RETMAN comics and rational stories; David, 2010). Knowing that children are gadget users, the future of REBT addressing this population lies in the continuous development of its tools and incorporation with technology. Steps have been made towards developing the first therapeutic cartoons, and robotic device, thus making REBT a pioneer in this field. Game-based online components of the RETMAN robotic system are currently in work for addressing mental health problems in adolescents. Future studies need to clarify the best ways in which the tools should be used for maximizing their benefits.

REBT can be integrated with family systems notions to work with parents. The theory helps identify clients' thinking that reinforces dysfunctional family homeostasis. The use of REBT techniques can eliminate parents' emotional disturbance freeing them to explore and follow more productive models of relating and parenting. There are important questions to be answered regarding parenting interventions concerning the long-term outcomes and mechanisms of change for children.

A substantial body of research supports the efficacy of REBT. However, this research has employed too few designs and been limited to comparing REBT with no contact or placebo controls. Future research could focus on identifying the crucial techniques of REBT, the problems and populations for which it is best suited, and more efficient ways of helping clients.

Case Study

Michele M. was a 10-year-old fifth grader, referred in February by her mother because of social problems. Michele had few friends in her neighborhood, and was teased by her classroom peers. She had one good friend in class for the past several years, Sangitha. Michele had had difficulty making friends for several years. Her mother believed that her social difficulties resulted because she was rigid, did not share well, and wanted things her way. In September of this school year, a new girl entered Michele's class and became friendly with her only friend. The newcomer set up a competition between herself and Michele for Sangitha's friendship. The newcomer teased Michele and encouraged the other girls to do the same. Michele frequently arrived home upset, and cried about her peers teasing her.

The mother revealed a history of academic difficulties in reading and spelling. Michele had been evaluated by the school psychologist and a phonetic learning disability was uncovered. Michele received resource room services during Grades 3 and 4. Her mother believed that Michele lacked confidence as a result of embarrassment over her reading and spelling difficulties. This past September, Michele was declassified and was no longer receiving any special services. Michele had an enmeshed relationship with both of her parents. They both responded to her social difficulties by engaging in play activities with her to compensate when she was lonely. Because her parents rescued her, Michele had few opportunities to develop social skills. An interview with Michele's teacher confirmed all the things Michele reported, and revealed that her peers were reinforced by Michele's behavior. Her classmates enjoyed seeing Michele upset and her immature behavior and emotional outbursts reinforced their negative view of her. The teacher felt sorry for Michele and gave her extra attention when she became upset.

An interview with Michele revealed that she became despondent when she saw the newcomer talking to Sangitha. She had automatic thoughts such as, "She will never

be my friend now." "No one will ever like me." "There must be something wrong with me." When teased, Michele became noticeably upset and would cry, go to the teacher to report how she was teased, or go to her seat and pout. When she encountered her tormentors between these torturous events, she either held her head down, so as not to make contact, or made nasty remarks to them. Her behavior appeared to keep the cycle of strife going. Michele was not good at sharing or making reciprocal arrangements with peers. When asked if she knew how to make friends with other girls in the class or how to respond to neutralize the fights when teased, she reported that she "had no idea." The psychotherapist pursued the technique of inference chaining and uncovered the following core irrational beliefs: "Others should come to me and be my friend." "I must be liked by the other kids, or it means I am no good." "It's too hard to make friends and I should not have to do it on my own."

Michele did not play well with other children and was described as selfish. She did not share the joystick on electric computer games with peers and always put on the TV program that she wanted to watch. When her mother was discussing an example of Michele's failure to share, she burst out, "But they should let me have my way, I shouldn't have to share to have them be my friends." She also reported thinking, "I can't stand to take turns and should not have to do it."

A case conceptualization was developed using REBT, behavioral, and systemic principles. Michele had two major problems, coping with teasing by the girls in her class, and making and maintaining new friends. Michele was prepared to perceive any indifference to her, any criticism of her, or any noninvolvement with her as rejection. Such activating events elicited the negative thoughts that she would never have any friends and was worthless. She felt either anxiety and/or depression. These emotions resulted in the behaviors of crying, pouting, and seeking attention and support from adults. These behaviors had the cyclical effect of reducing her desirability as a friend to her peers. Besides changing these core irrational schemata, Michele needed help in improving her inadequate social skills to make friends. Her teacher's and parents' attention reinforced her cognitive processes, her emotional upset, and the behaviors. Michele's parents' behaviors also had the effects of preventing her from developing new social skills. In addition, Michele had problems with frustration intolerance that interfered with her social skills and discouraged children from playing with her.

Because REBT is a multimodal form of psychotherapy, a comprehensive treatment plan was developed that included emotional and practical solutions, and used cognitive, behavioral, and systemic interventions. The following nine goals were identified:

1. Change Mr. and Mrs. M's emotional response to Michele's emotional upset from guilt and anxiety to concern.

2. Change Mr. and Mrs. M's behavior from rescuing Michele, and have them reinforce prosocial behavior and teach her coping rather than isolation and histrionics.
3. Change Michele's emotional reaction when she is teased by her peers from depression to sadness and coping.
4. Change Michele's anxiety about making friends to concern.
5. Teach Michele strategies to cope with the teasing and defuse these events.
6. Teach Michele social skills to make new friends and maintain the ones she has.
7. Change the teacher's behavior from reinforcing emotional upset to reinforcing prosocial behavior.
8. Teach Michele to share, and to make joint decisions and reciprocal arrangements with peers.
9. Increase Michele's frustration tolerance to allow sharing and reciprocal relationships with peers.

The first phase of psychotherapy was to work with Michele's parents. The psychotherapists elicited reports of their behavior toward Michele when she became upset. They were asked to consider how their reaction helped Michele learn to cope with the problem or how it would help her make friends in the future. They reported that they were aware that their behavior was not solving the long-term problem but that they felt so upset when she became upset, they thought they had to do something. The psychotherapist identified the goal of changing their emotional reaction to Michele's problem. Then the psychotherapist taught them the B–C connection and engaged them to look for the beliefs they had that made them upset. They reported thinking, "It is terrible to watch your child experience pain and I must do something to rescue her." The psychotherapist led them in a discussion of this idea and helped them replace it with the rational alternatives, "It is uncomfortable to watch your child have problems; but sometimes children have to learn to solve problems even if it is hard." "Rescuing fails to teach." "I can only teach her that she is strong and can cope by showing her that I believe that she can be strong and can cope." These interventions accomplished Goal 1. They would step up a reward system to reinforce Michele for not being upset and discussing her social interactions calmly, for focusing on how to cope, and for engaging in social activities with children in or out of school. They still did not know what to say to Michele about the other children teasing her. They and Michele agreed that one or both parents could be present in Michele's sessions. Usually the mother attended and we agreed that the parent present would discuss the session's proceedings with the absent parent. This partially accomplished Goal 2.

The next group of sessions focused on Michele and her experiences of being teased. The psychotherapist explored the factual nature of Michele's automatic thoughts. She was teased by a number of the most popular girls in her class. The psychotherapist

challenged Michele's demand that she had to be liked by these girls to be a worthwhile person.

Psychotherapist:	Do these girls like everyone in the class?
Michele:	Of course not.
Psychotherapist:	You mean there are other girls who are not their friends?
Michele:	Yes!
Psychotherapist:	Well, what do you think of these other girls who are not friends with the girls club (our term for the band of tormentors)? Are they worthless as well?
Michele:	I never thought of that. Of course they are not worthless!
Psychotherapist:	Well, why not? If you are worthless because you are not their friend, shouldn't all girls who are not their friend be just as worthless as you?
Michele:	No, some of them are nice kids.
Psychotherapist:	Even though they do not hang around with the girls club?
Michele:	I guess so.
Psychotherapist:	Can you tell me who these other girls are and what you think is good about them?
	(Michele described the other kids who were not liked by the girls who teased her and what their good qualities were.)
Psychotherapist:	Well, if these other girls can be good even though they are not members of the girls club, why can't you?
Michele:	Well, maybe.
Therapist:	You don't sound convinced. Maybe you have some good qualities even though you are not a member?
Michele:	Well, I never thought about it like that.
Psychotherapist:	Let's think about it. Do you have any good traits?
Michele:	I suppose I do.
Psychotherapist:	What would anyone find that is good about you?
	(Michele reported on friends she had over the years and why they may have liked her. Her mother reported positive things that other cousins and friends of the family had said about Michele.)
Psychotherapist:	Well, I guess you're not all bad?
Michele:	I guess not, but that does not make them like me.
Psychotherapist:	You are right, but do they have to like everybody?
Michele:	Of course not, they can't like everybody. There are only eight of them and there are more girls than that in my class. So I guess they can't be friends with everyone.

Psychotherapist: And there are other classes too, and other grades, too. Are all those girls who are not friendly with the club just *no good*?
Michele: I guess not.
Psychotherapist: Then why are you no good? What makes you different from the other girls that they do not behave friendly with?
Michele: I guess there is no difference. But I just think it about myself, not about the others.
Psychotherapist: Does that make sense?
Michele: No.
Psychotherapist: Why not? Why does it not make sense?
Michele: I am not sure. I just believe it about me, not about them.
Psychotherapist: Well, if they can be okay even if they are not liked by the girls club, why can't you?
Michele: I never thought about it that way.
Psychotherapist: Well try it. Just say the words out loud. "I am just as good as all the other kids. And I don't need to be liked by the girls club to be okay!"
Michele: I can't remember all that. (Psychotherapist repeats the statement, and Michele repeats it after three tries.)
Psychotherapist: Well, how do you think you would feel if you really thought that way?
Michele: I guess I might feel better.
Psychotherapist: Okay, let's practice getting you to think that way. What can we do to practice it?

After three sessions of similar dialogue, Michele felt much better about being teased. At Session 7, we enlisted her mother to tease her as the girls did and Michele would rehearse the coping statement that we had used in the above session. This accomplished Goal 3.

Once Michele had better control over her depression, the third phase of psychotherapy focused on learning new responses to the girls who teased her. Each session, she, her mother, and I discussed what the girls had done, continued to analyze her ABCs, and discussed what she could have said differently to the girls. We agreed that she would say nice things to them in between upsetting events, such as giving them compliments. When they teased her, she would ignore the content of their statements and assertively say, "I guess you are still trying to get me upset." We practiced these responses and had Michele role-play them with her mother between sessions. We agreed that each day Michele and her mother would review the events of the day and discuss how Michele was using the ABCs to keep herself calm, what the other girls actually did and how Michele could have

responded, and what opportunities Michele could have had to say nice or neutral things to the girls. This occurred for 4 weeks. Each session, Michele and her mother reported on their meetings, and the psychotherapist reviewed their progress and added information when needed. The role here was to be a coach. During this time, the psychotherapist also consulted with the teacher to try and ignore emotional outbursts by Michele, and reinforce her with praise for coping or giving a prosocial response. After 12 sessions, we accomplished most of Goals 2, 3, and 5.

The next series of eight sessions followed the same process but focused on reducing Michele's anxiety over approaching new friends in her class and teaching her what to say to make friends. We reviewed the automatic thoughts that occurred when she became upset and used inference changing to uncover her irrational beliefs. The psychotherapist challenged her irrational beliefs and discussed rational alternatives. We discussed homework, which involved approaching other children. Mrs. M continued attending the sessions and having her daily debriefing sessions with Michele. These sessions accomplished Goals 4, 6, and 7.

Once Michele had established some emerging friendships, the psychotherapy switched focus to Michele's behavior with peers. The target of the interventions was her irrational beliefs that she had to have her way and should not have to share. Again, Mrs. M continued attending most sessions with Michele, and continued her daily debriefing with Michele. In 10 sessions we made significant progress on improving her social skills and accomplished Goal 8. Throughout the last three stages of psychotherapy, the parents maintained and adjusted the reinforcement system set up to reward prosocial behavior.

Michele made considerable progress in psychotherapy. She was no longer depressed when teased. She handled herself well in social confrontations. She was always a little reluctant to make new friends, but pushed herself. She had new friends in class and in her neighborhood. She had also developed a new closeness with her mother. She enjoyed her debriefing sessions where she got another person's impressions of her behavior. She later transferred this behavior to close friends. Mr. and Mrs. M felt more confident in their ability to deal with their daughter, and they were more likely to let her try new activities. As of this writing, Michele is a sophomore in high school and has maintained all these treatment gains.

ANNOTATED BIBLIOGRAPHY

The Albert Ellis Institute website (http://albertellis.org/) maintains a list of books, DVDs, blogs, and audiotapes describing the theory and practice of REBT, video demonstrations of actual REBT psychotherapy sessions, a bibliography of the writings of Albert Ellis, treatment manuals for specific conditions, and an updated review of research supporting the theory of

REBT and its effectiveness and efficacy, and information funding research on REBT. Readers can reach the institute by e-mail at info@rebt.org or by phone at 212–535–0822.

The following annotated references include the most important works in REBT for those who want to learn more about the theory and practice of REBT in general and children, adolescents, and families in particular.

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CHAPTER

7

Reality Therapy Approaches

GERALD B. FULLER

Reality therapy was developed by William Glasser (1965, 1972, 1976a, 1976b, 1981, 1998, 2000, 2011) when he recognized that existing therapeutic systems did not produce rapid and durable change. The essence of reality therapy is the acceptance of responsibility by individuals for their own behavior, thus helping them to achieve success and happiness. Concomitant with this responsibility is the importance of personal involvement in all the therapeutic and growth processes. Reality therapy teaches better ways of fulfilling needs. It stresses the idea that, given an atmosphere of human involvement and supportive confrontation, an individual can learn how to behave in a more responsible and productive manner.

HISTORY AND STATUS

W. Glasser, in conjunction with G. L. Harrington, began the development of reality therapy in 1962 while working at a Veterans Administration hospital in California. During this same period he was the chief psychiatrist at the Ventura School for Girls, which housed 14- to 16-year-old females who had been labeled as incorrigibles. Here the principles of reality therapy were used in developing specific programs for the girls and for the school as a whole. These young women had, understandably, poor self-esteem, and one of Glasser's immediate goals was to build success into their experiences. The school became a place where honest praise was given freely. The girls were put in charge of themselves, thus giving them the responsibility for their own behavior. Rules were clearly defined, as were the consequences for breaking them. The praise and personal responsibility

helped shift the girls' attention away from the authority figures against whom they had rebelled.

The title *reality therapy* was officially introduced in an article dealing with juvenile delinquency (W. Glasser, 1964). The following year, his book *Reality Therapy* (W. Glasser, 1965) appeared. At approximately the same time, Glasser founded the Institute for Reality Therapy. Here therapists do both individual and group counseling and teach the concepts of reality therapy to both laypersons and professionals.

In 1966, Glasser began consulting in the California school system. His experience in the schools led to the publication of *Schools without Failure* (W. Glasser, 1969) in which he applied the concepts of reality therapy to contemporary education. He described the inadequacies of current educational procedures and suggested techniques aimed at reducing school failure. Again, these techniques were aimed at the children's involvement in their schooling, giving them a sense of self-esteem and a successful identity. He felt this whole process could best be accomplished by making education interesting and relevant, by retiring the grading system, by showing true concern, and by allowing the children to progress at their own speed. A good classroom, he asserted, should incorporate praise, active listening, and relevant helpfulness.

In 1969, as a result of the popularity of *Schools without Failure*, the Educator Training Center (ETC) was opened to handle the flood of requests for information and teaching materials. By offering materials such as films, cassettes, and books that emphasized the principles of reality therapy, the center helped teachers and other school personnel create schools without failure. So many children who appeared to have had adequate advantages (e.g., comfortable homes, security, and attention) were responding by failing in school, using drugs, and demonstrating an unwillingness to work for reasonable goals. Glasser's search for an explanation for this phenomenon led to his concept of role versus goal. This theory was the impetus for *The Identity Society* (W. Glasser, 1972). Here he discussed the replacement of a survival society where behavior is directed toward keeping people fed, clothed, and comfortable, by an Identity Society, where emphasis is placed on caring, involvement, respect, and satisfaction. Children gain strength and successful identities through involvement with others, and with these strength children can do what is necessary to reap the benefits available in the identity society. Glasser proposed that a person, in looking for ways to gain personal strength or confidence, could become addicted to positive behavior. These positive addictions—the antithesis of negative addictions such as drugs and alcohol, which make one weaker—help to make one stronger. Jogging, tennis, or reading could thus become positively addictive. These ideas were set forth in *Positive Addiction* (W. Glasser, 1976b).

In an attempt to fill the gap that often exists between theory and practice, a case study compilation entitled *What Are You Doing? How People Are Helped through Reality Therapy* was edited by N. Glasser (1980). A solid neurological and psychological base

was added to the clinical approach of reality therapy with the publication of *Stations of the Mind* (W. Glasser, 1981). Its thesis is that people are internally motivated and, thus, behavior is purposeful. Each individual may perceive a different reality, however, and this idea must be kept in mind when interpreting other's behaviors. What is motivating a particular child and what others think is motivating him or her may be very different indeed.

In *Take Effective Control of Your Life* (W. Glasser, 1984), Glasser describes his new control theory, which proposed that people can better their lives through conscious control of their emotions and actions. This was based on his theory that everything a person does, thinks, and feels comes from inside an individual and is not, as most people believe, a response to external circumstances.

In his next book, *Control Theory in the Classroom* (W. Glasser, 1986a), Glasser addressed the need for schools to restructure the classroom environment to keep students interested and involved in learning. He contends that students are currently not successful in school because school was not part of the picture in their heads that fulfilled their basic needs. Glasser proposed the use of a cooperative learning approach that would satisfy students' basic needs for fun, belonging, power, and freedom. Thus, students would be provided with mental pictures of learning in school that would be need fulfilling.

To demonstrate the role of control theory in the practice of reality therapy, a case study book titled *Control Theory in the Practice of Reality Therapy: Case Studies* was edited by N. Glasser (1989). These case studies provide interesting examples of ways that control theory can be translated into the practice of reality therapy.

W. Glasser (1990) in *The Quality School: Managing Students without Coercion* continued his thinking about schools by combining the work of Edward Deming with his own experience with education and control theory. He presented an effective management style for school based on many years of research. Glasser suggested that traditional management was the problem in school because it has turned students and staff into adversaries. He proposed a system that brings them together to produce quality schoolwork and quality teaching. Control theory was expanded by W. Glasser (1993) in *The Quality School Teacher*. He explained how a working knowledge of control theory can improve the relationship between teacher and student. Specific guidelines were given for teachers as they help their students achieve better. This was followed by *The Control Theory Manager* (W. Glasser, 1994), which provided insight to management on control theory, and discusses how focusing on leadership and rejecting coercion produce quality. His next book, *Staying Together: A Control Theory Guide to Lasting Relationships* (W. Glasser, 1996) provided substantial examination of intimate relationships, focusing on what characteristics make them last. While speaking in Australia in 1996, Glasser announced that he was going to start referring to what had previously been control

theory, as *choice theory*, and in 1998 published *Choice Theory: A New Psychology of Personal Freedom* (W. Glasser, 1998). Choice theory was really the mental health concept added to his reality therapy. It was the theory that supported reality therapy. The whole premise of choice theory was the idea that a person's actions are always within the person's control. He saw choice theory as an internal control psychology and the alternative to external control psychology.

In his latest book, *Reality Therapy in Action* (W. Glasser, 2000), he presents his new theory with the major part being case study examples. In the book he focuses on unsatisfying relationships as the main thrust in therapy. Relationships are now central to his approach to therapy, and it is much more important to help the client to fix this than talk at length about the symptoms of the problem.

In his latest book, *Take Charge of Your Life: How to Get What You Need with Choice Theory Psychology* (W. Glasser, 2011), he explained choice theory that allows individuals to learn how to improve their relationships and take charge of their actions. In one chapter of the book he explained how to apply choice theory psychology in raising children.

The Institute for Reality Therapy teaches the practice and concepts of reality therapy to professional people, interested groups, and organizations. Individuals are taught in 1-week sessions that include lectures, discussions, demonstrations, and role-playing situations. To become certified as a reality therapist one must complete a 1-week basic intensive seminar followed by a supervised practicum, which is arranged, a second intensive week, followed by a second practicum. The title *Reality Therapy Certified* (RTC) is given to individuals completing this 18-month program. The Institute is now called the William Glasser Institute.

The *Journal of Reality Therapy* was first published in the fall of 1981. This semiannual publication focuses on theoretical, a few research-based, and specific descriptions of the successful applications of reality therapy principles in field settings. An edited book by Litwack (1994) contains a selection of articles from the first 13 years of the *Journal of Reality Therapy*. The articles present an overview of the development of the concepts and practice of reality therapy. In 1997 the name of the journal was changed to the *International Journal of Reality Therapy*. In 2011, the name of the journal was changed again to the *International Journal of Choice Theory and Reality Therapy*. The majority of the articles are still without experimental and research-based evidence.

OVERVIEW OF THEORY

The following section presents the basic theory and assumptions of reality therapy. This includes the four basic needs children need to fulfill to acquire the feeling that they are basically successful and how these needs affect their relationship with others. How this works is explained through control and choice theory.

Basic Theory and Assumptions

Reality therapy purports that the driving force for all behavior is the basic, intrinsic goal of having a different, distinct, and unique identity. Each child wants to believe there is no other person quite like him or her anywhere on earth. To attain and maintain this identity, regardless of whether it is centered on success or failure, is critical.

Failure-identity children are those who believe "I can't do it. I'm no good. I'm not successful. I'm worthless." Believing they have little chance to succeed or to be happy, these children appear to have a distressing or negative attitude toward school and life. For them, the real world is uncomfortable. These children have given up and, for the most part, have resigned themselves to failure. They often see themselves as losers and lonely and do not care about themselves or others. They are self-critical, irrational, and irresponsible and have little to look forward to. *Apathetic, indifferent, uninvolved,* and *unconcerned* are some of the terms that are used to describe these children. School failure is personalized and so these children come to view themselves as worthless.

For children to acquire the feeling that they are basically successful or good, they must fulfill the following general or basic needs:

- *Love*: Belonging, friendship, caring, and involvement.
- *Power*: Importance, recognition, worth, and skill.
- *Fun*: Pleasure, enjoyment, laughter, and learning.
- *Freedom*: Independence, choice, and autonomy.

All people need to be loved and cared for from birth to old age; this includes groups as well as families. To love and be loved are necessary ingredients for successful growth and development. The child must learn both to give love and to receive it in return. This necessitates that there must be at least one person who cares for the child and for whom the child cares. Children's need for love and belonging can be seen in the interaction with the members of their family and with others in school. In school, this might be reflected in social responsibility. Children must learn to care for, to be responsible for, and to help one another. To the extent that the child becomes involved with others, the child who belongs or is involved is more successful than the uninvolved child who may well be lonely and suffering.

In addition to love, children also need power or a sense of importance. There are ways to satisfy this need for power that are positive and do not interfere with other people's needs. One positive way to meet the need for power is to receive recognition. It is important to remember that it is children's perception of what they do—helped by recognition from others—that gives them that ultimate sense of worth. To feel worthwhile and successful, children must maintain a satisfactory standard of behavior—they must behave in ways that will gain the love and respect of others. It is also necessary for them to behave

in a way and to perform so that what they do is worthwhile to them as well. To do this, they must learn to evaluate and correct behavior that is wrong and, most important, to give them credit when it is right. Children's being attuned to morals, standards, and values of right and wrong as well as to school behavior is linked to fulfillment of their need for self-worth.

Although belonging and self-worth are separate, children who love and are loved will usually think they are worthwhile. The overindulged child can be the exception. These children are loved too much. Their parents mistake the total acceptance of good or bad behavior for good discipline. Love does not mean blanket approval. When children receive love for behavior that they know is wrong, they do not feel worthwhile and, thus, may act out as a way of asking for limits. A child needs to learn that being the subject of someone's love does not in and of itself give him or her self-worth.

Children need time for fun and time to enjoy themselves and others. This must involve active participation in contrast to passive participation such as watching television. Children, who do not know how to enjoy life actively or how to engage in having fun, are often too serious. As such, they tend to stress the aversiveness of a problem and to exaggerate the significance of things. They may also be people who construct their time poorly; the delinquent child often has nothing better to do than to get into trouble. How much fun the child has at home and school is an important variable to evaluate.

Freedom is important to everyone. Reality therapy defines freedom as being able to do and say what you want within the limits of the laws of society and being able to express yourself without discount. Reality therapy encourages the client to look at the range of freedom they do have along with the responsibilities of this freedom. Discounts among family members and teachers and children are most destructive. Freedom from criticism does not imply no correction or a laissez-faire attitude. It means refraining from the little extra comments that teachers and parents so often make that chip away at the child's self-concept: "How dumb can you be?" "Don't you ever care about anybody but yourself?" Criticism of this kind tells children that they are not good people and pushes them toward failure identities. Criticism should always be directed at the behavior and not at the child or the person.

When children are not fulfilling their needs, they are unhappy and must do something to reduce their pain and hurt. Often the means they devise are ineffective, and, try as they might to succeed, they view themselves as failures. The concomitant loneliness, pain, and discomfort are often dealt with in four ways: depression and withdrawal, acting out, thinking disturbances, and sickness.

Control Theory

Since 1984, Glasser has integrated reality therapy with control theory, which suggests that the preceding basic needs are part of our genetic structure. Built into our brains

are these fixed needs that, if not satisfied, result in stress, tension, and suffering. At the survival level, these needs include food, shelter, and safety, whereas at the psychological level, they include the needs discussed earlier. Consequently, all our behavior is a constant attempt to satisfy one or more of the basic needs that are written into our genetic structure. When there is a difference between what we want (as perceived in our head) and what we perceive in the external or real world, the mismatch results in dissatisfaction. Often the child in need of therapy has chosen unsatisfactory behavior that attempts to meet, but does not alleviate, those needs which remain unfulfilled.

From one's general or basic needs, there is a world of specific needs that are not genetic but learned. We usually function at the level of these specific needs although we are also aware of basic needs. We refer to these specific needs as *wants*—specific perceptions related to a basic need. For example, swimming is a want related to the basic need for fun.

The mechanism through which needs are met is the inner world of wants, which is described by W. Glasser (1984) as a "picture album." Exploring the needs and perceptions in this album is a means of working with a child in therapy. This is also the first procedure that lends itself to change.

In a theory that explains how we live our lives on a daily basis, the brain is seen as a control system that seeks to control, maneuver, and mold the external world to satisfy an internal goal. Recently, Glasser has brought the theory to a clinical level with practical application (W. Glasser, 1984).

Choice Theory

The main premise of choice theory is that individuals have problems because of unsatisfying relationships. To make progress in human relationships we must give up the punishing, relationship-destroying external control psychology, which is the one most practice in the world. If the child is in an unhappy relationship in school or home right now, it is probably caused by the child or both the child and the school or home using external control psychology on the other. Glasser (1998) goes one step further. If, for example, children are depressed, their misery is usually related to a current unsatisfying relationship. This suggests that the problems are in the present, not in the past. No one can change what happened yesterday.

Choice theory indicates that a therapist should connect with the clients' inner quality world and establish a trusting relationship. Clients' inner quality worlds are a window into how they would like things to be in the present. Glasser (2000) indicates that children and adolescents have inner mental pictures that represent their quality worlds. These fall into three categories. The first is mental pictures of the people that they want most. The second is things they want and prize the most; and the third is the idea and belief that guides their behavior. Children and adolescents have their own unique quality world.

Glasser (2000) argues that external control psychology operates by using strategies such as blaming, nagging, criticizing, labeling, punishing, complaining, and so on. Glasser believes that clients must replace external control psychology with behaviors and techniques that strengthen and support relationships. As opposite to external control psychology, clients need to learn to love, support, negotiate, trust, and sustain relationships.

James and Gilliland (2003) suggest 10 axioms that drive freedom in the choice theory:

1. A client can only control his or her behavior and not that of others.
2. People can only give us information and how we process the information is a matter of personal choice.
3. Most psychological problems are relationship problems.
4. Relationships are always part of the client's current life.
5. The past does not determine behavior and that present relationships are what affect current behaviors.
6. Restates that clients are driven by genetic needs: survival, love and belonging, power, freedom, and fun.
7. Clients meet their needs by satisfying pictures that are in their quality world.
8. All behavior is total behavior and is made up of four components: doing, thinking, feeling, and physiology.
9. Clients are not depressed but they are choosing to be depressed and in reality therapy terms they are depressing and clients are not suffering from anxiety, but they are choosing anxiety.
10. Clients can control their feelings and physiology indirectly through what they choose to do or think. Hence most behaviors are chosen.

VIEW OF PSYCHOPATHOLOGY

One of the main premises of reality therapy is that individuals have problems because of unsatisfying relationships. These problems can be demonstrated in any of the following four ways:

Depression and Withdrawal

Unable to reduce the pain of failure and loneliness through acceptable and realistic means, children withdraw into the self-involvement of unhappiness and depression. Children behave in a way that causes them to feel depressed and then use that feeling as an excuse for an inability to handle problems. In reality therapy terms, a feeling such as depression is called depression because it is viewed as a feeling behavior. Depression is not something that comes over children, but rather is something they actively choose

and help create. The child would rather be depressed than admit to an inability to figure out better behaviors for belonging and getting along. In the child's view, it is better to use depression as an excuse than to admit to not knowing what to do. Depressing provides a rationalization for continuing uninvolved behavior. After all, how can anyone expect depressed children to become involved with others when they feel so bad? The successful child when feeling depressed realizes that something must be done, whereas the unsuccessful child fights to maintain the depressing behavior because it provides some temporary relief. To give up the depressed state would be to expose oneself to the pain of feeling like a failure—unloved and worthless. To experience this is more than the child wants to do. Depressive behavior may have some value, however, if it can be seen as a child's request for help.

Acting Out

Another way to relieve the pain of failure and worthlessness is to act out. Many children strike out in an effort to get rid of pain by hurting people they believe are denying their needs. They are often indifferent to social rules and reinforce their lack of regard for others by putting the blame on someone else. These children are not afraid of punishment; they often expect it. Having identified and reinforced themselves as failures, they often become antagonistic, breaking home and school rules. Because they feel they will fail anyway, they attempt to gain what they want while expending as little energy as possible. Needing to fulfill this identity, they assert that they are someone—a failure—and they use this as a rationale for their capricious behavior. Consequently, when they are punished, these children often feel victimized or persecuted. The punishment they receive can serve as a source of involvement because they obtain attention through their acting-out behavior. Punishment is painful, but it is better than being alone.

Thinking Disturbances

Some children, either unable to figure out a satisfying behavior or having tried and failed, attempt to meet their needs by living in a world of their own. They deny reality in an effort to reduce pain. Once self-involved, they do not have to deal with the pain of failing and not being involved. For these children, their own world becomes the real world. All their seemingly crazy thoughts and behaviors make sense; it is an attempt to avoid a world that they fear they will be unable to control.

Sickness

Some children manifest somatic complaints such as headaches, stomachaches, nausea, or dizziness with no physical causes present. It may be better to stay in bed than to face a hectic day at school. If children are too sick, they cannot possibly do schoolwork.

For these children, the aches and physical pain are very real, making it impossible to carry on a normal day. By causing the child to be sick and helpless, the behaviors keep anger in check and allow the child to be offered help or to seek it. Probably more than most other behaviors this one allows for sympathy and attention. Somatic illness has the added attractiveness of reassuring the child and his or her teacher and parents that the problem is physical rather than social or psychological.

General Therapeutic Goals and Techniques

Although reality therapy places some emphasis on behavioral change, more importance is given to goals that are concerned with values, relationships, and concepts of individual responsibility. A strong focus is placed on helping individuals understand and accept themselves as they are and to improve their relationship with others. One of the most important needs is love and belonging and to be as close and connected with people we care about, which is required for satisfying most of our needs. If we are disconnected or not close it is seen as the source for most problems that we encounter. Individuals' achievements, within the limits of inherited endowment and environment, are what the individuals make of themselves. Decisions, not conditions, determine the way a person behaves and whether the person acts responsibly or irresponsibly. Other goals might include developing the ability to express mature and responsible love, and the ability to give and take. Self-awareness should move toward increasing the client's ability to focus on present concerns and to avoid rehashing the past, particularly mistakes, and dwelling on the distant future. Soon clients will be able to act out more responsibly to solve personal crises more effectively and to fulfill their own needs without hurting others or themselves (W. Glasser & Zunin, 1979).

Reality therapy is a verbally active psychotherapy. A conversational exchange occurs between therapist and client that may include agreements and disagreements. Clients are confronted with their irresponsible behavior. Constructive arguing will focus on showing the client more responsible ways of behaving. The therapist may attempt to pin down the clients in terms of what the clients intend to do about their current life situation. A statement such as "I might look for a job" will be met with questions such as how and when, with the therapist not accepting excuses. Throughout the therapy process, the therapist directs the client to focus on real-life issues and is concerned with what the client does and what the client plans to do.

The steps for child and adolescent therapy outlined in the next section are essentially similar to the principles (e.g., see W. Glasser & Zunin, 1979) that guide all reality therapy. Reality therapy begins with the therapist communicating a caring, personal involvement to the client. The focus is on present behaviors and concerns, helping the clients make their own value judgments on whether the behavior is responsible, and assisting the clients in making plans to change failure behavior to success behavior.

Then the therapist strongly encourages the clients to make the commitment to act out on the value judgments and to carry out the specific plans formulated. The therapist does not accept excuses for failure, yet does not punish the client when failure occurs. Throughout, the therapist takes an encouraging, client-advocate stance.

INDIVIDUAL PSYCHOTHERAPY WITH CHILDREN AND ADOLESCENTS

Because the basic approach of reality therapy in working with children and adolescents is essentially the same, no distinction will be made between techniques for these age groups.

Step 1: Involvement

This step has also been referred to as "be personal or make friends." Because children who are acting irresponsibly and have a failure identity are lonely and alienated, it follows that an important technique to use is to become involved with them. Involvement is a therapeutic prerequisite for anyone who hopes to be helped. Often this step is not given the importance it should have in the therapeutic process. Beginning therapists hear this and agree in principle but are often overly anxious to move on to the *action* of therapy. However, a therapist's skill in dealing with a child depends heavily on this first step.

Children must be made to believe that the person working with them is concerned. The therapist needs to be warm, supportive, interested, and genuine in the relationship. Unless this can be done from the beginning to the end, the therapy will seldom be successful. Convincing the child that you want to be involved is demanding, requiring a good sense of humor, patience, and acceptance. The child needs to be convinced that another person cares and is willing to talk about anything that is of interest to the child rather than just focusing on what has gone wrong. This makes it essential that the therapist have a good grasp of child or developmental psychology. It is important to know about the current television programs, movies, CD's, or books in which children at different ages are interested. In addition, hobbies, recreational activities, and peer relationships should be explored.

What the child says must be respected, although one does not have to agree with it all. If the child makes contradictory statements or is unclear, the therapist should strive for clarification by saying, for example, "I don't understand" or "I'm confused." The therapist should be open and honest with the child. It should be made clear that the therapist is willing to talk about almost anything the child wishes to discuss. Initially, as little emphasis as possible should be placed on the child's present symptoms or behaviors; this has been done enough in the past. The therapist should not focus on problems or misery first. This only reinforces behavior by giving value to the failure and self-involvement.

The less the therapist discusses the problem and instead stresses the possibilities open to the child, the better.

The question of how much time to give the child in therapy often arises. To a child who is lonely and uninvolved, the friendly therapist becomes a much-desired source of needed gratification. It is impossible to be extensively involved with every child in a time-consuming relationship, especially within a school setting. The therapist should never promise more time than can be given. Most children can accept honest statements from the therapist about time commitments once involvement is established. Whatever the amount, it is usually more productive and rewarding than what the child has had previously.

During this first step, it is important to ascertain what the child wants. The therapist should begin where the child is, not where the therapist thinks the child is. Suggesting what the child might want is counterproductive. Helping children to examine wants and to establish priorities demonstrates early on that the children need to begin taking responsibility for their actions. A brief summary by the therapist during or at the end of the session helps children know that the therapist is paying attention. It also gives children a chance to hear their wants, something the children may never have listened to before. In addition, it gives children an opportunity to correct any misinterpretation. This summarizing technique continues to be valuable throughout therapy.

Step 2: Focus on Present Behavior

By focusing on present behavior, the therapist asks the child, "What are you doing?" This question is used in place of the "why" question of conventional therapy. The emphasis is on the present—what the child is doing now or what is planned for the future. Reality therapy sees focusing on the past to be of little use. Dwelling on the past only reinforces the apparent importance of past experiences and their association with the child's present problems. The only way children can work toward a successful identity is to become aware of their current behavior, which is usually caused by unsatisfying present relationships. This approach does not deny that problems can be rooted in the past. But we can basically only deal with current behavior in order to plan a better strategy for the future; we cannot undo what has already occurred. Acknowledge the child's past, believe in it, but focus on the present.

This does not mean that the therapist never asks about the past. If the therapist thinks that knowing something about the past will help plan for more suitable behavior now or in the future, such information should be pursued. However, the therapist should look for the past successes to use as building blocks for a better now and tomorrow. Talking about past failures often reinforces the child's use of them as an excuse for present behavior: "My brother was this way and so am I," or "I have a temper like my mother's and that's just the way I am."

Reality therapy purports that children's behaviors are a combination of their actions, thoughts, and feelings. To the child who is upset, it may seem, however, that these feelings are most important. The therapist should not ask children how they feel unless the feeling is associated strongly with what the children are doing now or plan to do in the future. Talking about a feeling may temporarily make the child feel better, but it does not change anything and is worthless in the long run. Feelings should be tied to the behavior that evokes them. This helps the children to understand that they can and must change what they are doing to find relief from this present misery. In essence, behavior is readily observed and responded to; feelings are not. If changes are to occur, it is easier to start with behavior than with feelings. This does not mean that the therapist rejects the feelings but tries to point out that the way the children feel may not be as important as the way the children behave. The therapist might respond, "I believe you; you are upset, you are angry, but what are you doing?" It is hoped that this will redirect the children's attention to their responsibility for the behavior. If the child is depressed and is complaining about sitting at home all the time on weekends feeling miserable and thinking unhappy thoughts, the therapist can listen to the upset feelings but stress the sitting-at-home behavior. The therapist might ask, "Is that what you are choosing to do?" The idea is to focus more and more on the activity or the lack of it rather than on the misery and upset conditions. It is easier to change the sitting-at-home behavior than the depressed feelings or miserable thoughts.

Asking angry, acting-out children about feelings is counterproductive and may produce more anger and hostility. Focusing on what children are doing and putting less emphasis on feelings may actually reduce frustration. The anger is not the cause of the problem, but rather the result of an inability on the part of the children to satisfy their needs.

It is a basic premise that the behavior the child exhibits is chosen. The therapist must keep in mind that children very seldom see their behavior as having anything to do with the problem. Children usually see the world—not themselves—as needing to change. This has often been referred to as an external locus of control. Also, children may see themselves as victims of things over which they have no control.

Step 3: Value Judgment

The important question to be asked here is: "Is what you are doing helping you?" or "Is what you are doing against the rules?" Children must determine if the behavior is good for them and for those the children care for and if it is socially acceptable. Because children act by choice, they must make the judgment whether to continue the behavior. This is the child's responsibility. Here the child begins to answer the question "Is it helping?" Children will not change until they determine that the behavior does not help accomplish what is wanted. What is actually being asked of the child is, "Are you

doing what will help you fulfill your needs? The therapist should be very careful here to remain nonjudgmental about the child's behavior; the child is being asked to make the judgment." The therapist prepares the child to make this judgment by using what was established in the preceding steps—the examination of the present behavior and the trust that comes with involvement. The value judgment may include a decision about what the child wants. "So you really want to quit school? Can a boy of 16 find a good job? Are you willing to live with the hassle of school?"

Often there is no clear choice about which behavior is the best or most responsible. In some cases, such as obtaining independence from parents, it is difficult for the child to make a choice. If the child is unwilling to make the judgment that what is being done is not helping or that it is against the rules, nothing can be planned or accomplished. No one can make individuals do anything as long as they are unwilling to accept the consequences of their behavior. The most the therapist can do is to continue to strive for increased involvement that will encourage a move away from failure.

Step 4: Planning Responsible Behavior

Once children have judged that their behavior is not helping and want to change, it is the responsibility of the therapist to help the children make a plan to do better. This is the time to examine the possible alternatives to the child's present behavior and to help the child find new behaviors that lead to a better connection. Both the positive and negative alternatives should be discussed. Children often have a limited repertoire of behavioral responses, making it difficult for them to suggest many alternatives. Initially, the therapist may have to generate some ideas. More than one idea or alternative should be presented so that children can choose the one most acceptable to them. In some cases where the therapist must make a plan for children, it is important to establish that children think they can carry it out. Actually, it does not matter who makes the plan as long as it is accepted and becomes the children's plan. It is hoped that the child will learn new behaviors via the plan of action developed. Sometimes, planning proceeds by trial and error; that is, a plan is developed, attempted, and perhaps modified until one is found that fits the situation.

The therapist should be aware that making plans takes skill and that the following critical components must be considered:

- *The plan must be small and manageable, in terms of both time and what the child is going to do*. For example, a child might do 15 minutes of homework for each of 4 days. If the plan is too large, it will only reinforce failure. The child needs to feel successful. To allow the child to say, "I will not fight from now on" is setting the child up for future failure. It would be better for the child to say, "I won't fight in the next 2 hours." Only after initial successes can the time be prolonged.

- *The plan must be specific, definite, and detailed.* It should be something the child can visualize doing, like completing a math assignment. Key words for the therapist to use here include what, where, how, when, with whom, and how many. The plan should also depend on what the child does rather than what others do: "I will clean my room every Monday if you let me stay up and watch TV" is an unsatisfactory plan; "I will clean my room every week" is better.
- *The plan should be reasonable.* It should make sense, and the child and therapist should see the value in doing it.
- *The plan should be positive.* The focus should be on what the children are going to do rather than on what they are not going to do.
- *The plan should begin as soon as possible.* The longer children wait to put a plan into effect, the less likely they are to do it.
- *The plan should be repetitive.* It should be something that can be done often or something that can be easily repeated each day. This helps form daily patterns of the new behavior.

If the plan fails, the therapist must have the ability to think of another one or to help the child replan. If, in the attempt to make a new plan, a problem comes up that seems unresolvable, rather than force the issue, it is better for the therapist to relax and just chat with the child about an interesting subject. In time, it is hoped, child and therapist will be able to return to the difficulty during the session and resolve it.

After a plan has been made, it is often wise to return to the value judgment step. The therapist should ask the child if the plan is workable. "The therapist might ask the child, for example," "Is the plan reasonable or is it asking for too much?" It is also beneficial to have the child repeat the plan to be sure that the child understands it. This clarification again points out the potential value of summarizing.

If children carry out the plan, this accomplishment is the beginning of their becoming more responsible; this concept cannot be overly stressed. The therapist will have to emphasize repeatedly that children must take the responsibility, that things in life cannot always be done for them, and that they must live their own life. The child must recognize that the therapist will be of help for a while but that all the therapist can do is to get this process started. The child must come to the realization that eventually all people must assume responsibility for their behavior and live in a world much larger than the restricted world of therapy.

Step 5: Commitment to the Plan

After the child makes the reasonable, workable plan, a commitment must be obtained that the plan will be carried out. The child is being asked, "Will you do it?" This is an important stage in plan making because it shifts the responsibility to the child.

Commitment is both motivating and binding. It means that the child is no longer alone. What children do now is not only for themselves but also for someone else. This helps provide a sense of strength and purpose.

Getting the failure-identity child to make a commitment is not always an easy task. Having already failed on a number of occasions, these children are often reluctant to commit themselves again for fear of exposing themselves to more painful rejection and consequent feelings of worthlessness. Commitment is also involvement, which may be met with resistance. However, until the child is willing to make a commitment to something or someone else, it is likely that the child will remain self-involved and unable to develop a success identity.

The commitment is made either verbally or in writing. A written commitment is preferred because it is stronger, more binding, and clearer. There is little doubt about the conditions of a commitment when they are written out and signed by the child. It is a good idea for the therapist to sign it also, thus demonstrating involvement. Two copies of the agreement are made, one for the child and one for the therapist as a backup in case the child loses the copy. This approach may sound too businesslike and legal, but it is a fact that a person is more hesitant to escape from a written commitment than from a verbal one. It also avoids disagreements over the terms of the plan.

Step 6: Accept No Excuses

Plans do fail sometimes, and the therapist must make it clear that excuses are unacceptable because they break the involvement and allow the child an opportunity to avoid responsibility. Excuses, if allowed, do provide temporary relief; they reduce the child's tension and improve feelings on a short-term basis. The excuse undermines the need for action because momentarily the child is off the hook. Too frequently, teachers and parents accept apologies such as "I'm sorry" because it is easier to accept the apology than to go through the time-consuming process of assessing responsibility and present behavior. It is also very possible that the child could interpret the acceptance of excuses as a lack of concern. The accepting of an excuse also implies that the child's inadequacy and inability are also accepted.

When the child does not follow through on the commitment to the plan, the therapist asks, "When will you do it?" or "When will it happen?" or "I'm glad you are sorry, but what are you planning to do so that this same thing doesn't happen again?" It may be necessary to alter the plan. The child is not discounted or punished for failing. Actually, without punishment or rejection, there are no good reasons for excuses.

When the commitment fails, the plan must be reevaluated. If the plan is still reasonable, the child must decide whether to commit to it again. At this point, a value judgment must again be obtained from the child, and a new plan and commitment

formulated. A good way to reduce excuses is to ask for a value judgment every time the child gives an excuse. Often, the making of an excuse is evidence that the child has not fully understood the value judgment that was made. The therapist might say, "Do you want to work at getting along with your teacher or do you want to give up?" Returning to the value judgment often helps put the therapy back on the right track.

A teacher faced with excuses might say, "If you don't do your assignment, I will not punish you, but I do insist we work out a better solution. I don't care why you didn't do the assignment; I will accept your thinking that you have a valid reason. However, we have to solve the problem. We have to find a better way for you to follow the rules and get your schoolwork done."

Step 7: Do Not Punish

This step probably elicits the most controversy. Many successful people regard the fear of punishment as the prod toward achievement. As a result, punishment has enjoyed a solid reputation in our society. Punishment, although never good, can serve as a deterrent to the success-oriented child who may have strayed momentarily from the path of responsibility. With the child who is a failure, however, punishment often reinforces the failure identity; the punishment only confirms the child's low self-esteem and can even sanction other reckless behavior.

The goal here is not to put more pressure on the child than is now being experienced. This step recognizes and accepts that children do not function well when they are hurting. It proposes that although there is not to be any punishment administered, minimally painful, reasonable consequences (i.e., appropriate discipline) have value.

Criticism is also unacceptable. Many children who fail actually expect the therapist to be critical and hard on them and may attempt to provoke this attitude. If the therapist succumbs, the child will use the therapist's behavior to continue excusing inadequacies. This is a popular game played by failing children. A nonpunitive, noncritical therapist will not become involved in the child's inadequate lifestyle.

Reality therapy defines punishment as any treatment that is intended to cause a child mental or physical pain. Punishment is to be distinguished from natural consequences or discipline. A comprehensive list of the differences (Table 7.1) between the two is given by Dreikurs, Grunwald, and Pepper (1971).

This step does not imply that reality therapy is passive, permissive therapy. Discipline is an essential part of reality therapy for children. Reasonable, agreed-on consequences for irresponsible behaviors are not punishment but discipline. Logical consequences set out the reality of social responsibility. In any given situation, it is necessary that the rules be learned. The establishment of consequences and the understanding of rules help to eliminate the element of the unexpected. Children should suffer reasonable

Table 7.1 Differences Between Punishment and Discipline

Punishment	Discipline
1. Not appropriate for (related to) the action. Too severe.	1. Appropriate for the action. Not too severe or meaningless.
2. Unexpected because the punisher has reacted on the spur of the moment.	2. Expected because the individual has been informed of the rules and results of infringement.
3. Often delayed.	3. Immediate consequences.
4. Expresses power of a personal authority	4. Based on logical consequences expressing the reality of the social order.
5. Punishment imposed. Responsibility is that of the punisher (no choices).	5. Discipline assumed. Responsibility is that of the individual (choices offered).
6. Focuses on stopping past negative behavior.	6. Focuses on teaching present and future positive behavior (e.g., mistakes are seen as chances to learn). Solution orientation.
7. Focuses on external control of behavior.	7. Focuses on reinforcing internal control of behavior.
8. Reinforces failure identity (confirms low self-esteem and may increase rebellion and hostility or withdrawal).	8. Emphasizes teaching ways that will result in a more successful identity.
9. Often is, or is seen as, an expression of anger and hostility.	9. Should be friendly—a partnership.
10. Easy, expedient, and requires little skill.	10. Difficult, time-consuming, requires much patience.
11. Often alienates the individual.	11. Strengthens the relationship over time as consistency demonstrates caring.
12. Expression of moral judgment by punisher.	12. Individuals' own value judgment of their behavior.
13. Often seen as linked to the punishee rather than to the act (doer is wrong).	13. Linked to the act (emphasis is on the deed).
14. Only recognizes results.	14. Recognizes effort as well as results.
15. No opportunity for individual to redress wrong.	15. Opportunity for individual's retribution or repair.

consequences when they break the rules. Yelling at children adds nothing to the learning process and only makes things worse. The child might now suffer what is perceived as the loss of parental or teacher approval and is burdened additionally with the work of reconciliation.

If the child breaks the rules at school or at home, reasonable consequences must follow. The most reasonable of these is deprivation of either a freedom or a privilege. The child might be asked to sit in a chair at home or school until a plan is worked out. A quiet place to sit, to do schoolwork, to think, provides the child with the opportunity to get over the upset and to think about a plan. After an appropriate length of time, the teacher or parent should approach the child in a mild manner offering an opportunity for problem solving. If the child is ready, they then return to Step 4 and continue planning from there.

Children should not be allowed to criticize themselves unless it is part of a value judgment or is tied to a plan to correct the problem. Even under these circumstances, such criticism should not be accepted but rather dealt with. If the child says, "I'm no good; I never do right," the therapist might reply, "I don't think I can go along with that. You go to school every day on time, and some of the time, from what you say, you do well. You are also here which shows a willingness not seen in everyone. You are doing some things right."

It is also important that the therapist refrain from criticizing the child. Instead, the therapist might say, "Is what you are doing helping you or anyone else?" or "I think I can suggest a better way; let's discuss it." The child has an option in the second statement and is assured of help in doing better. During all of this, the child is learning a better way to handle problems and to cooperate with another person.

Step 8: Never Give Up

This last step is a reminder to the therapist. No matter what the child does or says, the therapist should continue to convey the attitude of persistence long after the child wants the therapist to give up. Not giving up will, it is hoped, solidify the idea for the child that someone does care. Often the child begins to work only after receiving this assurance.

Wubbolding (1995, 2011) has suggested that reality therapy is not a series of steps and they do not have to be followed in the order that was given above. He sees reality therapy as a cycle and can be entered at any point. Wubbolding has developed the WDEP system to demonstrate the cycle of reality therapy. The acronym WDEP involves the following components:

- **W** evaluates the wants, desires, and commitment to change of the client. He lists five levels of commitment and sees these levels as being hierarchical (i.e., higher levels represent higher levels of commitment):
  1. I am not thrilled about being here.
  2. I want the results, but I do not want to go through the process.
  3. I will try.
  4. I will do my best.
  5. I will do whatever the task requires.
- **D** involves the therapist evaluating what clients are doing and consists of total behaviors, which are composed of doing, thinking, feeling, and physiology.
- **E** is where the therapist helps the clients to evaluate their behaviors, wants, needs, level of commitment, and plans. This is the assessment of the effectiveness of the clients' behaviors.
- **P** is a plan that should be based on self-realizations. The plan should help the clients to obtain their needs.

Wubbolding (1995) has also listed five interventions that the therapist should be aware of when conducting reality therapy:

1. Always be courteous.
2. Always be determined.
3. Always be enthusiastic.
4. Always be firm.
5. Always be genuine.

These interventions are necessary to build strong relationships and involvement with clients.

REALITY THERAPY AND CHOICE THEORY

W. Glasser (1998, 2000) has asserted that the methods of reality therapy are consistent with the concepts of choice theory.

The goal of reality therapy in counseling or teaching is to help children and adolescents gain more effective control over their life and to form better relationships. In the classroom, teachers can use these same ideas to help the students become aware that it is beneficial to work hard and succeed academically. In either case, the goal is to help children to become more responsible. To accomplish this, children are asked to look honestly in the direction the behavior is heading and to determine whether this direction is satisfactory both immediately and in the long run. If either the direction of their life or the behavior they are choosing in order to move in this direction is not as satisfying or effective as desired, the goal of reality therapy is to help find a more effective behavior, a better direction, or both.

To do this, the steps of reality therapy have been expanded and reworked into two major components of reality therapy counseling (W. Glasser, 1986b): the counseling environment and the procedures that lead to change. These components should be used together if counseling is to be effective.

Counseling Environment

The counselor must attempt to develop an environment in which the clients feel secure enough to make an adequate evaluation of the effectiveness of their present behaviors. Clients are then helped both to learn and to attempt different behaviors in an effort to find more effective ways to meet their needs that involve relationships with others. The success of therapy depends on maintaining this environment throughout the counseling relationship.

The counseling environment needs to be perceived by the child as safe and positive. Children come or are brought to counseling when some aspect of their life is not in

effective control. It is critical for children to see the therapist as a person who is capable and interested in assisting them to find better choices for behavior. Therapists need to present themselves as persons who are not overwhelmed by the problems of the children and their family. To do this, therapists should avow confidence in the children's ability to learn to live life more responsibly and effectively.

The therapist must remember that clients behave according to the perceptions of their own world (as held in the mind). We must realize that what the client perceives may be very different from what the therapist and others close to the client might perceive. Early in therapy, time is directed toward helping the client understand that these differences exist. Learning to deal with these differences becomes the next step in therapy. Unless the client can learn to get along better with those who perceive the world differently, it will be difficult to satisfy needs effectively.

Clients are more successful when they recognize and accept the responsibility for a chosen behavior. The role of the therapist is to maintain a relationship with the child that:

- Is simple and easy to understand.
- Creates goals that are within the reach of the child.
- Helps the child avoid excuses and accept responsibility.
- Emphasizes the child's assets and strengths.
- Gives the child a chance to learn and to try new and more effective behaviors.
- Creates changes that are observable and helpful.

Procedures That Lead to Change

First, the therapist needs to focus on the child's total behaviors; that is, how the child is acting, thinking, and feeling at the present time. Next, a child must learn that these total behaviors are chosen.

To effect this, ask the client what is wanted now. If the client does not know, continue to focus on the choices and the resultant direction in which those choices are taking the client. The critical question to ask here is, "Does your present behavior have a chance of getting you what you want now and will it take you in the direction you want to go?"

If the answer is no, this implies that the clients' directions are reasonable, but that the present behaviors will not get them there. At this point, therapists should help the clients plan new behaviors. For example, "I want to improve my grades but to do so I will have to study more."

At times, clients are unable to move in the right direction regardless of how much effort they put forth. If this occurs, the therapist should ask the client to consider changing directions. For example, "No matter how hard I study, my grades do not improve.

I may have to consider a tutor." In this case, the plan now focuses more on changing the direction of the behavior than on the behavior itself.

If the answer to the critical question is yes, the behavior will get the client what is wanted now and will achieve the desired direction. Such an answer indicates that the client sees nothing wrong with this current behavior or the direction it is taking.

Before a plan is attempted, both client and therapist should agree that it has a reasonable chance of success, and a commitment should be given for follow-through. Usually the client who makes commitments tends to work harder. With younger children, a written commitment is generally more effective than a verbal one.

The therapist should remember that clients choose their behavior and that the best behavior is always that which the clients believe can be accomplished. To this extent, the behaviors are *effective* for the client. The therapist must also be aware that a client will not change a behavior until it appears that the present behavior will either not result in what is wanted or will not take the appropriate direction. Change becomes possible only when clients believe that another available behavior will allow them to satisfy needs in a more acceptable way.

Reality Therapy Techniques

The following techniques are used in the application of these steps of reality therapy:

- *Humor*: The therapist may use humor to help the child understand that things are not as serious as they appear. It can be used for confronting issues such as irrational behavior or lack of responsibility. It also helps clients develop the healthy ability to laugh at themselves. The message in humor is that life can be better, that there is hope, and that laughter is good medicine.
- *Confrontation*: Facing the child with a here-and-now, no-excuses stance is definitely confrontational. Most confrontations require client action: A value is pushed, and the client is challenged to look for alternatives and is encouraged to formulate a new plan. This technique is often used when children are unable to shake the mistaken ideas or beliefs behind their behavior.
- *Contracts*: A written contract is often used in therapy. A signed contract serves as evidence of the client's intent to change behavior. It also specifies those changes in written form. Completion of a contract, like the fulfillment of needs, promotes feelings of self-worth within an individual. Here is evidence that the child can work responsibly toward a goal and succeed. Contracts may be one-sentence agreements such as, "Jack will speak to one new friend by Friday," or they may be quite detailed. The therapist and client each should sign the contract and keep a copy of it.

- *Instruction*: When a specific skill is needed to formulate a new course of action, instruction may be needed. This can be part of the therapy session if the therapist has the needed competence or, if not, the child can be referred elsewhere for skill instruction. If at all possible, the client should be encouraged to assume responsibility for the instruction/learning process.
- *Information*: The child often needs specific and new information for a plan of action and the therapist should be ready to provide it. If the therapist does not have the information the client requires, the therapist should assist the client in finding it. It is the therapist's responsibility to have available a list of probable and reliable sources.
- *Role playing*: Role playing is often used when a child is experiencing difficulties in interpersonal relationships or needs to practice a new behavior. Role playing is frequently followed with a feedback session—a discussion of what the client and therapist experienced while playing the roles of others. The session often affords the therapist the opportunity to encourage clients by emphasizing what they did well. Role playing also offers an opportunity to focus on nonverbal behaviors that are part of successful behavioral interactions.
- *Support*: Support is used to increase the child's awareness, anticipation, and expectation of a positive outcome. Children with a failure identity need much support, especially when putting their plans into action. They have learned to expect failure and do not want to take any further risks. Encouragement and support are paramount if children are to commit to a new or different behavior. Support can be given by (a) asking the children's opinion, (b) requesting the children's evaluation of their present behavior, (c) providing praise for successfully completing a plan, and (d) expressing confidence in the child's ability to change. If successful, this approach will usually increase the child's motivation and serve to communicate feelings of worth.
- *Homework assignments*: Homework is used to build continuity between sessions and to facilitate counseling by encouraging the child to work on problems between sessions. Typical assignments include trying a new behavior, reducing or stopping a present behavior, keeping a record of current behavior, or researching solutions to a specific problem.
- *Bibliotherapy*: The goals of bibliotherapy include (a) allowing children to see the similarity between their problems and those of others, (b) encouraging free expression concerning problems, (c) looking at alternative solutions, (d) helping the children to analyze attitudes and behaviors. When using bibliotherapy, be sure to discuss the readings with the child. Discussion should be focused on feelings, thoughts, behaviors, and consequences. Make certain that the children see the relationship between the reading and their own life. Bibliotherapy can be

viewed as a form of cognitive restructuring directed toward educating the child about certain areas of concern such as sex, divorce, or death. Suggested books for bibliotherapy can be found without difficulty.

- *Self-disclosure*: Some self-disclosure by the therapist is usually needed to obtain involvement with the client. Because reality therapy calls for active and equal participation of both the client and therapist, there may be times when therapists are asked how they deal with certain problems. In such circumstances, relevant to therapeutic goals, the therapist can share personal experiences.
- *Summarizing and reviewing*: Because clients often give the impression that they are listening when they are not, it is advisable to have the child summarize what was said or discussed in the therapy session. This can be done halfway through the session and/or at the end of it.
- *Restitution*: It is better to help the student make restitution for a behavior than to apply punishment. The goal of this technique is to assist the student in developing self-discipline. Children are helped to understand that they can learn to remedy their mistakes. One does not focus on the fault or the mistake. The focus is on making things right. The therapist's job is to offer information and examples, answer questions, demonstrate, and question. Some restitution options are to fix it, pay back, say several positive things about another child, or give time in lieu of payment.
- *Questioning*: Use questioning to gather information, especially to clarify what was said. Well-timed questions help clients think about what they want and evaluate whether their behavior is leading them in the right direction.
- *Paradox*: This technique was introduced into reality therapy by Wubbolding (1988). It is designed to counter strong resistance to a plan that is not carried out. The usual approach is to ask the client not to continue the plan, to go slowly in carrying it out, or to keep breaking it. Sometimes the best way to make desired changes is to do so indirectly. This involves looking at the subject's behavior in an inverse way.

GROUP PROCEDURES WITH CHILDREN AND ADOLESCENTS

Once the therapist has established involvement and a relationship with the child, it is still necessary to convince the child that such relationships are also available with others. Reality therapy can be used with groups as well as with individuals. At this point in treatment, the advantages of group therapy become apparent. The group offers the opportunity for involvement and provides more support, need satisfaction, and assurance than any one individual can provide. There is also more opportunity for safety in risking

or trying new behaviors. Often, too, when children listen to and become involved with other children, they become less self-involved. The group also allows a wide range of feelings and thoughts to be expressed. Instead of having only the therapist who cares for and approves of the child, there is now the potential for the child to experience approval from the whole group. Being part of the group means that the child has an opportunity to get personal, to be warm, to show concern, and to develop more responsible behavior. This gives the child a taste of success and the chance to feel better about him- or herself.

Become Involved

In the initial stages of the group, the therapist takes an active role. Responsibility and caring must be molded while getting the group members involved with one another. The therapist becomes involved with each member of the group, asking questions, requesting information, and encouraging comments. It is advisable to use games, value clarification, or group projects during the beginning sessions rather than to focus on problems. As in the first step of reality therapy with individuals, being friendly is important to involvement; it may take five or six sessions to get the group running smoothly.

Focus on Reality

The therapist must help the groups to focus on reality. After involvement has been established, the attention is focused on present behaviors and problems. Events discussed in the group should be kept to a minimum. The children are encouraged to evaluate and analyze, with the therapist asking such questions as: "What are you doing?" "What do you want?" "Is it doing you any good?" "Is it against the rules?" These questions help the children focus on the reality of the situation. The therapist does not evaluate the behavior but helps the children to become more aware of the behavior and to reach a decision about it. The children, however, may evaluate behavior and can also offer specific suggestions concerning how they would handle certain problems.

Make a Plan

Initially, therapists will be very active in plan making. It will more than likely be up to them to develop alternative plans or different choices. However, therapists must always encourage the children to become actively involved in this process. The therapist is cautioned to help make a reasonable plan that will have the best opportunity for success. After a plan has been decided on, a commitment is obtained from the child or children involved. If the plan does not work, the therapist must firmly refuse to accept excuses; no one should be let off the hook. The therapist should be supportive and encouraging by asking, "Are you going to carry it out?" but the therapist must not punish or allow the other children to punish.

Establish Rules

The therapist, together with the children, must see that rules are established and consequences are set up if the rules are broken. For example, it might be established that one must raise a hand to speak to the group. The first time children do not follow this rule, a warning is given; the second time the rule is broken, the children must leave the group until they feel able to follow the rule; the third time, the children must leave the group and may not come back until they present a plan for following the rule.

Group Makeup

Many therapists, because of time demands, put all their problem children in one group. A group made up solely of children with acting-out behaviors, history of truancy, or academic difficulties is destined to fail. If one purpose of the group is to help children with failure identities, it makes sense that they should be involved with or come into contact with children who have successful identities. For the most part, children with failure identities learn very little that is responsible from other children with failure identities. Truant children have little that is constructive to offer another truant—if anything, they may reinforce and support the truant behavior. A child with a good attendance record may be more likely to help the truant as this child is already living more responsibly and can offer strength, encouragement, and support of the failing child. The successful child may be able to think of several alternatives or different choices for the problem situation and may also help in the development of a plan. It is important to include successful children in the group whenever possible.

Group Size and Duration

The size of the group will depend on the purpose of the group and the setting in which it occurs. However, 8 to 10 children are more than enough to work with at one time. With younger children, the therapist may want to begin with a smaller number. The group must meet regularly, thus giving the children the opportunity to plan to attend and to assume responsibility for being on time. Age becomes an important variable when considering a time frame. W. Glasser (1969) recommends that primary school children begin by meeting for 10 to 15 minutes per session, increasing to 30 minutes per session. Fourth, fifth, and sixth graders can easily meet for 30 to 45 minutes, and high schoolers for 45 minutes to an hour. The minimum number of meetings for all age groups is once a week; two or three times a week is more desirable.

Time of Day

A morning time is preferable when the children are fresh. Meetings should not be scheduled before recess or lunch.

CLASSROOM AND EDUCATIONAL APPLICATIONS

If one were to poll junior and senior high school-age children concerning their objections to school, many would reply that school has no relevance to the real world and that, although they are forced to go, they simply put in their class time, waiting for the 10 minutes of socialization between classes and the half hour at lunch. Those who comply with the system often complain that they are learning to memorize, not to think. Or those who have gotten on the memorization railroad, ride it all the way to the perfect A report card, the graduation with honors, and the scholarships waiting at the end of the line. Either way, there are prevailing feelings among these students that school is something to which they submit, that apathy serves better than taking on the system, and that teachers and the administration do not care as long as they get paid. Although it may be harder to elicit these feelings from the elementary school children, they are there, expressed in the child who reaches over and crumples a classmate's paper, or who wanders aimlessly around the room, or who bullies on the playground.

The Classroom Meeting

Fun, freedom, power, and belonging—the four components of a successful identity if one follows the thinking of reality therapy—are for the most part missing from our educational system where an "If you want to pass, you'll do it my way" attitude prevails. It is possible, however, at any level to begin to help students (a) become involved in developing goals of their own, (b) form better relationships with one another and with their teachers, (c) experience success, (d) gain confidence in their control over their education, and (e) enjoy the process.

The vehicle that has offered students a feeling of belonging and of social responsibility, that has given them an opportunity to both give and receive concern, is the classroom meeting. Basically, there are three types: (1) open-ended, (2) education-diagnostic, and (3) social-problem solving. These meetings allow the teacher to apply some principles of reality therapy in the classroom.

The *open-ended meeting* centers on thought-provoking questions related to the children's lives. The teacher presents hypothetical questions designed to enable the children to become involved. The discussion that follows is aimed at stimulating and developing intellectual curiosity. Any topic of interest to the class can be used. There are no right or wrong answers, only alternatives. Topics might include any number of relevant issues (depending, to an extent, on the age of the children) such as war, politics, taxes, or abortion. At no time should the teacher or leader of the group make value judgments.

Education-diagnostic meetings are directly related to what the class is studying. Teachers may use this meeting to evaluate their teaching techniques and the current curriculum. This kind of class meeting provides an alternative to objective testing and helps

determine whether the children are learning the material being taught. The meeting is informational—"How much have my students learned?"—and is not used for grading. It is seen as an efficient method for determining the children's strengths and weaknesses in a given subject. The discussion should provoke individual thinking and allow the children to correct false or misguided information.

The *social-problem-solving meeting* deals with any individual or group problems of the class or school. Problem solving is the major thrust here. Solutions, it should be pointed out, never include punishment or faultfinding. This type of meeting gives the children some feeling of control over their lives. Loneliness, attendance, grades, and individual behavior problems are legitimate issues for discussion. The meetings should not strive for perfect answers but should at least work toward clarification of problems that may very well not have solutions. The child learns that it is beneficial to discuss problems and learns to recognize that there is more than one way of dealing with a problem.

All these meetings should be conducted with everyone seated in a circle. The circle provides the children with a feeling of acceptance because they have been allotted an equal amount of space with one another and the teacher.

The initial role of the teacher is to generate questions that will arouse the children's interest. A basic technique to help stimulate interaction among the children is what has been called a *floater*. This is a statement that does not call for an answer; it is simply a comment sent out for response. Teachers should not feel a need to fill voids or silence; instead, they can offer another nondirective comment or can simply wait for a response. It is critical that the teacher respond to early statements by the children in a way that will not turn them off. This is best accomplished by remaining relatively value free. For example, even a very good response should not be praised because such praise may inhibit some of the other children from offering what they then believe is a comment of less importance. The teacher should, however, indicate an appreciation for the contribution. Children who fail to volunteer might be brought into the discussion by saying, "You are paying attention; would you like to comment?" or "Think about it and let me know if you come up with an idea or answer." It is important that the teacher be supportive of any child's effort and discourages any attempt to criticize a child. If one child is dominating the group's time, the teacher can handle this situation by saying, "Thanks for your comments; let's hear from someone else now."

When a student behaves in a way that is disruptive to the other students in the class, this student needs to be confronted and helped by the entire class. For this type of situation, the social-problem-solving meeting is held. Here the so-called problem children hear what the other children think of their behavior. The teacher needs to be more in control of this type of meeting to ensure that it does not become a free-for-all. The reason for the meeting should be explained to the class (e.g., to discuss that a child has been stealing from other children). It is suggested that the group might be able to help

the child to act in a more responsible manner. The children are asked to state what this child has been doing that interferes with them personally. The children are encouraged to tell the child directly what the behaviors are and the effects that these behaviors have had on them. After each person in the group, including the teacher, has had a chance to speak, the children with the irresponsible behavior are given a chance to explain what others have done to interfere with them. At this point, the meeting moves quickly from getting all the facts out on the table to doing something with the information that has been obtained. It might be suggested that the class and the child involved offer some possible solution to the problem that would be acceptable to everyone. The teacher listens to all the solutions and then tells the group to narrow down the alternative plans and solutions. Last, the child is asked to pick a plan and commit to it. The class members are also asked to commit themselves to doing anything that will help the child carry out the plan. The conclusion of the meeting is an agreed-on, manageable plan.

These class meetings are basically techniques used by individual teachers in their respective classrooms. A school-wide approach to discipline or problem solving has been formulated by W. Glasser (1974) and is presented in the next section.

Ten-Step Discipline Program

Reality therapy is a common sense, nonpunitive approach that helps the children figure out what to do when their behavior is displeasing to themselves or interfering with the rights or needs of others. It focuses mainly on personal involvement and is structured toward helping the children plan, and commits them to a plan that will make their lives better. Reality therapy helps children gain a sense of belonging and personal worth.

Based on the principles of reality therapy, a 10-step, school-wide approach for dealing with problem children has been developed. The approach deals with problems by means of a constructive, no-nonsense but nonpunitive method built on a positive teacher-student involvement, but it does not accept excuses in place of results. Built into the program are alternatives to consider when something does not work.

For example, Jack has behavior problems in school. It is now February, and despite several conferences with the principal, the school psychologist, and Jack's parents, nothing seems to be working. Perhaps Jack comes from a poor home background or is an only child or is the last child of a large family. He has barely learned to read and may have had few good school experiences. Whatever his problems, the teacher now has Jack in the classroom for an entire school year, and if the teacher cannot get him to cooperate, Jack will suffer and the teacher's life will be miserable.

If the following 10 steps to better control are followed by the teacher, Jack may be helped to change. His behavior can become, though not perfect, improved enough to reward all the efforts. No miracles will occur; it is hard, slow work. A period of several months is probably a good minimum time commitment.

This 10-step program is divided into three parts: Steps 1 through 3 look realistically at how children are dealing with their problems and are concerned with what can be done to decrease or reduce these problems. Steps 4 through 6 give the teacher a simple, practical approach for working with the children and getting the children to identify, evaluate, and plan alternatives to their unacceptable behavior. Steps 7 through 10 consider resources within the school and/or community that can be used if the children refuse to change the behavior or continues to break the rules.

Steps 1 to 3: What Am I Doing Here?

Step 1: What Am I Doing That Isn't Working?

Set aside some time and make a list of the things you currently do when Jack upsets you. Ask yourself: "What am I doing? Do I yell at him … threaten him … ignore him?" Be honest and look at the efforts you have made to help the child. For the next few weeks refrain from doing the things you have on the list that have not been working. When you are tempted to use old methods, look at the list and ask yourself: "If they didn't work before, what chance do they have of working now?"

Step 2: A New Start

If you have decided that your present techniques are not working, consider stopping these behaviors. Promise yourself that tomorrow, if Jack manifests a problem, you will attempt to act as though this is the first time it is occurring. Stay away from such statements as, "You are doing it again," or "I have told you a thousand times, stop it." Do not remind him that his behavior is repetitive behavior. If, however, he does something right or good, even though he has done it before, reinforce him: "Jack, it's really neat when you sit still," or "I appreciate that." A pat on the head, verbal recognition, or an approving nod is helpful in telling him he is okay. A fresh start for him, if not for you, may make a big difference.

Step 3: A New Strategy

Plan at least one thing you could do for Jack that might help him have a better day tomorrow. It does not have to be a big deal. This step is based on the adage, "An ounce of prevention is worth a pound of cure." Whatever you do should have a positive aspect, such as a pat on the back as soon as he comes in, a special errand, or a "Good to see you, Jack." It can be anything that shows your personal concern for him. Fifteen seconds of unexpected recognition can mean a great deal. Commit yourself to these little plans for several weeks. The hope is that Jack will get the idea that he has some value in your class. Do not expect to be repaid with changed behavior immediately. Jack did not develop his problems overnight nor will he become a pillar of responsibility in just a few days.

Initially, he may reject you even more than before. You must stay calm and be persistent. Remember, these first three steps are aimed at changing your attitude and strategy.

Steps 4 to 6: Who's in Control Here?

Step 4: Calm Direction

Even if you have some success with the first three steps, at some point Jack is going to demonstrate the problems again. Perhaps when you ask him to pay attention, he will daydream and not respond. Act as if this is the first time he has ever done this (Step 2), and ask him to pay attention and begin his assignment. You might also say, "Please stop it." It is hoped that your improved relationship with him through the first three steps will now help him to do as you ask and he will focus on the task. If he does not respond, walk over to him and help him get started. Do this in a quiet manner, possibly putting your hand gently on his shoulder at the same time. At this point, you might say, "Can you now do your work?" If he does not agree to do his work, do not give up; you still have six steps left. You are trying to establish that although he must take responsibility for not doing his work, you are willing to help him get started. If he accepts this, that ends it. You are not blaming, yelling, or threatening. If this step works, say nothing more except to give him some reinforcement such as, "Jack, I knew you could do it."

Step 5: Question Time

If Step 4 does not work, ask the child one or both of the following two questions: "What are you doing?" and "Is what you are doing against the rules?" Often the child will say nothing or refuse to answer. If this happens, say, "This is what I say you are doing and it is against the rules." In essence, you are saying that Jack should be doing his work. You will have to be insistent. You are telling him that he is breaking a rule. Although he might try to evade the issue, you should continue focusing on the rule. These questions may be all you need to ask to help him begin working. You may also continue by asking, "Can you make a plan to follow the rules?" or "Are you willing to do your work?"

Step 6: Develop a Plan

Go through Step 5 briefly, and, if it does not work, tell the child in a very firm voice, "We have to work this out. We have to make a plan that will help you follow the rules or change your behavior." What you are looking for here is more responsible behavior. It will be necessary to make some time available to talk with him about making a plan. If it cannot be done immediately, you might say, "We will work it out later." The time it takes to do this is usually much less than the time you spent with procedures that did not work. The plan has to be more than "I'm sorry" or "I'll stop it." It has to be a doing plan

that will help the child move toward more responsible behavior. You might say, "I am glad you are sorry, but what are you going to do so it won't happen again?" The plan should be short, specific, and concrete. At first, you may have to put many of your ideas into the plan. Gradually, as he does better, the child may make more contributions to the plan. In Jack's case, you might say, "You do not want to do your work, but there are rules. Can you make a plan with me so you can get your work done? Let's try to work it out. Why don't we take some time and talk this over. It doesn't appear you are having much fun and maybe I can help you." Jack may be quite cautious at first, believing that this will just delay his ultimate punishment. Tell him he will not be punished and that you would like to help him work it out. Listen to his complaints; talk with him; get to know him better. Try not to bring up old behaviors or faults but instead stress that rules are important and you believe he can follow them. You may want to put the plan in writing; such a contract helps keep the commitment. You are saying to Jack that he has the power to make a good plan. Developing a plan does take some time, but it is a lot better than the techniques that have failed in the past.

Steps 7 to 10: Hope at the End of the Rope

Step 7: Someplace Close

Assume that Jack still manifests a problem or disrupts again and you are convinced that the previous steps will not work. Now it is time for the child to be isolated, or "timed out." The decision for time-out may be made by you or it could have been established as a natural consequence at the planning level in Step 6. This isolation is done right in the classroom. You need to create a place where the child can sit that is comfortable but separate from the class. If this is impossible to do, a desk could be set up in the hallway within viewing distance from the door. This conveys to the child that he is no longer involved in active participation in the class. The child can listen but cannot take part in classroom activities until a plan to follow the rules is worked out with the child. The child needs to inform you of the plan and make a commitment to carry it out. This plan should be mutually agreed on. If Jack continues his behavior, then say, "Go sit over there." Try not to say anything else. Be firm and quick and send him without discussion. Do not be upset if he spends hours or most of the day there. Isolation has a way of making the everyday class routines look more attractive. It is important that the child learn that rules cannot be broken, and the best way to learn this is through experience. You might, when you think Jack has had enough, ask him if he is ready to return to his seat and participate. If the answer is yes, at your next break, go over the rules and ask him if he has a plan to follow. Remember you are trying to teach him something in a few months that he has not learned over a period of many years. If the child continues the behavior in isolation, the child's only alternative is to be excluded, and yours is to move to Step 8.

Step 8: Someplace Farther

In-school suspension is involved in this step. You have tried, you have been patient, but now you have had enough. At this step, there are no questions to be asked. You can make this statement, "Jack, things did not work out for you here. We have both tried hard to work out the problems but now it is time for you to spend time outside the class and maybe talk with some other people. Please report to the Counselor's office [or the Principal's office, or the in-school suspension room]." The room or place should be staffed by a person who can get the following idea across to the child: "We want you in school and class but we expect you to follow the rules. When you have a plan as to how you can return to class and follow the rules, let me know. If you need help carrying out the plan, let me know and I will help you." What you want to get across to the child is that the plan will be different and better than what was used in the past. To get Jack to change his behavior is the task for which a new environment as well as new approaches are necessary. Do not be concerned if he sits there for a time. The whole idea is used to reduce the alternatives to two choices: (1) to be in class and behave, or (2) to be out of class and sit. It is hoped that the class will begin to look better. The point that needs to be communicated to the child is, "Follow reasonable rules, or you are out." However, while he is out, you are not going to hurt or reject the child, which would let the child rationalize his behavior on the basis of his dislike for you. This kind of nonpunitive place may be hard for the school and you, the teacher, to accept, but review Step 1 again—you can see the child has been in the "old" place a long time with no results. Be ready for a lot of excuses from the child; follow them up with, "But you cannot go back to class until you have a plan." When more than one day is required, you should notify Jack's parents that their child is not in class. It may well be that 3 days to a week or more will be required. Perhaps the child's schoolwork will suffer (although he could do schoolwork while in in-school suspension). It is hoped that the child will learn one of the most important things that can be learned: Children must be responsible for their own behavior and they do have the choice to behave in a way helpful to themselves and others.

Step 9: A Day Off

If Jack cannot be handled in an in-school suspension, the parents should be notified and asked to take the child home. The child will now be put on "a day off" with the idea that he can return the following day. One could say, "We would like your child to return, but we must maintain reasonable behavior. If his behavior goes beyond the rules, he will have to go home again." This means that Jack starts again at Step 8, or at in-school suspension, and can stay until his behavior changes for the better or until he reaches Step 9 again. If the child cannot be helped in school at all, then he will have to stay home, which means either having a tutor at home or the school's proceeding to Step 10.

Step 10: Someplace Else

If Jack is continually unsuccessful in Step 9, he should stay home and be referred to some other community agency. This may sound tough, but it may take something like this to jolt the child into taking some responsibility for his behavior. If the child is in jail or juvenile detention, perhaps he could return to school for a day to see if he can make it, but not unless a specific plan and commitment have been made to follow the rules.

PARENTING SKILLS

A Parent Involvement Program (PIP) has been designed to help parents gain the necessary reality therapy skills (McGuiness, 1977). Many of the activities demonstrate ways to facilitate increased involvement with one's children. Other aspects of the program attempt to teach parents better listening skills and to reflect to their children the good they see in them.

The program is accomplished in six 3-hour sessions, which can be conducted on weekends or evenings during the week. Each of the sessions has a definite content to provide parents with knowledge about a skill to be used in dealing with their children. The sessions are based on practice after they receive the theory. The sessions are structured to allow the parents to personalize the ideas, share their concerns, and develop a plan to improve things at home.

The objectives of the program for each session contained in the *Idea Book for the Parent Involvement Program* (McGuiness, 1977) are outlined in Table 7.2.

The parents are involved in a number of activities including:

1. Viewing films and listening to tapes that include:
   a. *Identity Society*.
   b. *Reality of Success*.
2. Using worksheets that include:
   a. Reality therapy planning form.
   b. Questions to accompany "Success-Oriented Home Exercises."
3. Reading articles such as:
   a. "Basic Principles in Dealing with Children."
   b. "How to Drive Your Child Sane."
   c. "Rules, Goals, and Failure."
   d. "Your Child and Discipline."
4. Discussing ideas in small and large groups.
5. Making personal plans to meet the needs of the family.
6. Participating in role playing to allow for practice of what is being presented.

Table 7.2 Parent Involvement Program

Lesson Objectives	Topics Covered
1. To build trust and support among group members. To help parents understand the cultural shift that has occurred since World War II. To help parents understand these cultural changes are affecting their relationship with their children.	Group involvement. The Identity Society role versus goal-activities.
2. To help parents realize the importance of building warm personal, friendly relationships with their children. To help parents understand a problem-solving approach (reality therapy) to helping children become responsible.	Importance of involvement. Successful versus failing identities. Principles of reality therapy.
3. To give parents insights that will help them reflect to their children the goodness and beauty that they see in them. To share with parents ideas that enhance total family involvement and help create a success-filled atmosphere for the home. To develop with the parents a personal plan that incorporates the concepts basic to reality therapy.	Practice in using steps of reality therapy. Total family involvement. How to increase involvement at home.
4. To share successes and concerns based on the activities developed from each parent's personal plan.	Successful experiences. Communication. Components of good listening.
5. To help parents improve their communication skills. To clarify any misconceptions concerning the understanding and use of the basic steps of reality therapy. To expose parents to current authors who have written significant articles in the area of parent-child relationships.	Nonverbal communication. One-way versus two-way communication. Discipline techniques.
6. To help parents gain insights in working with their children, based on articles read and shared with each other. To help parents clarify for themselves the basic concepts introduced and to share with their families the spirit of the workshop.	Review and feedback.

W. Glasser (2011) in his book titled *Take Charge of Your Life*, devotes an entire chapter on how choice theory can be used in raising children. He suggests that there are basically only two ways for the parent to deal with a problem situation; negotiate and/or compromise. He suggests using the following four steps:

1. Check the picture in your head of what you want from the child or adolescent and be sure what you want is also reasonably satisfying for the child or adolescent. If the rule is broken, be sure it is reasonable, which means it is one that

most children would follow and that you would be willing to follow as a child or adolescent.

2. Try to wait until both of you have calmed down, and then, with demonstrating as little anger as possible from you in the situation, ask the children or adolescents if they are satisfied with what they are doing or if they understand that it is against the rules.
3. When the children or adolescents are not satisfied or admit to breaking a rule, negotiate a better way for them to satisfy themselves and you. If you are involved in this plan, make sure that what you do is as much *with* and as little *to* or *for* the children or adolescents as possible. It is better when they can carry out the plan by themselves.
4. When the children claim to be satisfied with what they are doing and do not want to change, then, if you have the power, invoke a sanction that does not cause the children to lose control. The sanction is always some loss of a privilege or freedom until the problem is worked out. Make sure that the children or adolescents are able to change; if they need help, offer instructions or arrange for outside help, but do not do it for the children. Whatever the loss, it should be appropriate for the individuals' age and long enough for the children to see some sense in negotiating. It should not be so long that they give up and do not try to correct the situation.

FAMILY INTERVENTIONS

Reality therapy does not at present offer a framework for family therapy in the traditional sense. Family therapies usually identify the family as the client and do not focus on an individual, identified client. In family therapies, the focus is on systems, relationships, structures, and interdependencies. Reality therapy emphasizes developing the individual's successful identity and encouraging personal responsibility.

The family therapy focus on environmental influences on behavior is somewhat at odds with reality therapy. Family therapy views individual problems as stemming from a dysfunctional family system or structure, whereas reality therapy views individual problems as resulting more from individual identity and choices. Thus, the two approaches are not entirely compatible.

The reality therapist, however, does have some tools to use with problems that have family components. The first is the Parent Involvement Program, previously described. This allows work with families where problems seem centered on a need for more parental involvement with children and a need for the parents to provide more positive feedback to their children. The second tool is marital therapy or conjoint marital counseling (W. Glasser & Zunin, 1979), to be used when the family problems seem to

be a result of marital discord. This type of therapy is often time-limited, usually 5 to 15 sessions. This marriage counseling begins by clarifying the couple's goals in seeking counseling. Questions would be directed at determining whether the goal is, on the one hand, to continue in the marriage or, on the other hand, to attempt a last-ditch effort to save the marriage even though a decision to end it has already been made. Attention would also be focused on defining the couple's similarities and differences in opinion and interest, on how the couple seeks friends and other activities, and how much the couple actually knows, as opposed to assumes, about each other. The overall goal is intimacy, not simply familiarity.

EFFICACY

There are numerous favorable books on reality therapy, two published casebooks (N. Glasser, 1980, 1989), a survey of Glasser's work (Bassin, Bratter, & Rachin, 1976), and a compendium of articles on reality therapy (Litwack, 1994). In addition, seven books have been written by Ford and others (Ford, 1974, 1987, 1989, 1994; Ford & Englund, 1977, 1979; Ford & Zorn, 1975) that discuss the techniques and principles of reality therapy as applied to discipline, raising children, marriage, loneliness, and stress. A book by Robert (1973) discusses the use of reality therapy in the school situation to deal with loneliness. Wubbolding (1988, 1991, 2000, 2011) has written four very useful books demonstrating the practical uses of reality therapy. Good (1992) proposed a nontraditional approach to communicating with children for parents and teachers using the principles of reality therapy as the framework for her ideas. Gossen (1992) presents in detail how restitution, a key approach to discipline, is used in reality therapy. Crawford, Bodine, and Hoglund (1993) proposed a number of changes for schools to be successful. Their book introduced an agenda for transformation by addressing the multiple issues that a school must consider in order to move toward being a school for quality learning. They drew heavily on the teachings of William Glasser. Myers and Jackson (2002) present a book that is based on implementing reality therapy in a juvenile facility. A major theme in the book is to help juveniles make better choices and to help them improve their relationships with others. It is a specific "how to" workbook that explains what to do clearly in a correctional situation. Erwin (2004) offers many useful management and instructional tips to teachers based on reality therapy. He offers hundreds of specific strategies one can use with students to appeal to what intrinsically motivates them in order for appropriate learning to take place. The book focuses on a new classroom management model that aligns itself with what motivates a student's behavior. A book by Jackson (2005) focuses on violent girls who bully. He presents 14 chapters dealing with the problems of female bullies and their victims and what can be done about the problem. Throughout the book it is demonstrated how he uses

choice theory and reality therapy to build relationships with three different girls and for them to choose more effective behaviors.

The methods and techniques of reality therapy and their justification appear reasonable and have been accepted by many professionals in the field. Reality therapy follows certain tenets in attaining involvement and influencing responsible, realistic behavior:

- Becoming involved—personalization.
- Concentrating on the here and now.
- Emphasizing behavior.
- Refraining from asking why.
- Helping the client evaluate behavior.
- Developing a different or better plan of behavior.
- Refusing to accept excuses.
- Never punishing, only disciplining.
- Offering little sympathy.
- Approving and praising responsible behavior.
- Never giving up.

There certainly is no lack of testimony concerning the efficacy of reality therapy. However, in these books there is no adequate statistical evidence or support for reliability and validity. W. Glasser and Zunin (1973) reported there had been no long-term research on the effectiveness of reality therapy with outpatients. Follow-up work at the Ventura School for Girls, however, indicated that the use of reality therapy in the treatment program had reduced the recidivism rate for that environment (W. Glasser & Zunin, 1973).

Radtke, Sapp, and Farrell (1997) performed a meta-analysis of 21 studies using reality therapy and found the 95% confidence interval for the population effect to be −.072 (lower limit) and .808 (upper limit). This suggests that reality therapy may or may not be helpful. They found that reality therapy had some positive application mainly for school-based issues. The power value for the 95% confidence interval was .38, suggesting low power overall. The authors indicated that additional meta-analysis, experimental and quasi-experimental studies were needed.

Murphy (1997) did a search of PsycLit from 1980 to 1995 on the efficacy of reality therapy in the schools. The author found six studies that had been conducted regarding reality therapy in the schools. She concluded that to one degree or another reality therapy was effective. However, it was pointed out that these studies lacked experimental control in many areas. Included here were issues of voluntary participation, measures used, sample size, length of intervention, and training of teachers. Overall this may suggest that reality therapy may be working to improve behavior in the schools, but because of the lack of sound research, there is little to substantiate its efficacy.

Some studies have focused on classroom meetings and their effect on self-concept, social adjustment, locus of control, and achievement. Matthews (1972) studied the effect of class meetings on the discipline, self-concept, social adjustment, and reading achievement of 221 fourth and fifth graders. Treatment consisted of 16 weeks of a language arts program in the control group and reality therapy in the experimental group. Pretreatment and posttreatment data were collected on three tests. His findings indicated that both treatments increased self-concept scores but neither change was significant. It was also found that neither treatment was significantly better in improving social adjustment. However, reality therapy was found to be significantly more effective in lowering the incidence of discipline problems in the experimental group compared with the control group.

Zeeman and Martucci (1976) utilized an open-ended classroom meeting over a school year in a special education class of nine learning disabled 10- to 11-year-olds. As the school year progressed the authors reported that verbal participation increased, while impulsive behavior and hyperactivity decreased. They also suggested that these meetings were especially helpful in enabling "isolated" children to develop the "success identity" necessary to draw them into positive relationships with other children.

Hunter (1973) reported no significant findings when studying the effects of reality therapy and Rogerian group sessions on math achievement, self-concept, and behavior of 40 fifth-grade students. The students were matched on sex and randomly assigned to a math remediation, a Rogerian discussion, a reality therapy, or a control group. Six weeks of treatment (twelve 40-minute sessions per group) resulted in no significant change in math achievement, self-esteem, or behavior in any of the groups.

Tangeman (1973) investigated the effects of a reality therapy program on the achievement and self-esteem of 93 third graders. Four classrooms were randomly assigned to two treatment approaches: (1) reality therapy class meetings and (2) Developing Understanding of Self and Others (DUSO) and two control groups. Twenty 30-minute meetings were held for each group over a 10-week period. Pretest and posttest data from two tests were analyzed. The results indicated no significant changes for any of the groups on self-concept or achievement.

Hawes (1971) evaluated the use of reality therapy on the locus of control, self-concept, and classroom behavior of 340 third- and sixth-grade Black students. Three tests were administered for pretest and posttest evaluation. Reality therapy class meetings were employed for a 16-week period, with a control group receiving no treatment. The results showed that the reality therapy program did significantly shift the children's belief system toward an internal orientation. A significant change in behavior was also found, as the reality therapy group demonstrated more appropriate changes on the self-concept measure.

Shearn and Randolph (1978) evaluated the effect of reality therapy class meetings on self-concept and on-task behavior for fourth-grade children. In an attempt to construct a "true placebo control" design, the authors randomly assigned four intact classes (27 students in each) into four treatment conditions: (1) pretested reality therapy, (2) unpretested reality therapy, (3) pretested placebo (career education activities), and (4) unpretested placebo (career education). Several tests were administered to all the groups. Pretest and posttest scores were collected for one experimental and one placebo group, while only posttest scores were collected for the other experimental and control group. The results indicated that treatment, pretesting, or the interaction of treatment and pretesting for posttest scores had any significant effect on self-concept or on-task behavior. The authors concluded that their findings do not support using reality therapy in the classroom. They did caution that the inability to measure the effects of reality therapy empirically in the classroom is a factor that confounds interpretation of research in this area.

Quinn (1979) used seventh- and eighth-grade children to investigate the effects of class meetings on self-concept and attitude toward school. Three seventh- and eighth-grade classes were randomly assigned, each to one of the following groups: (1) class meetings, (2) a quasi-experimental group (performing plays), or (3) a control group (no treatment). Pretest and posttest scores were collected on self-concept and school attitudinal scales. The results failed to demonstrate any significant changes in self-concept or improved attitude toward school. Here nonsignificant results may have been a function of insufficient time for behavioral changes to occur.

A study by Grant (1972) used open-ended class meetings to investigate possible changes in self-concept and locus of control of 163 fourth-grade pupils. Classrooms were randomly assigned as open-ended classroom meetings. Each treatment group met in twenty-nine 30-minute meetings over a 6-week period. All children were rated by their teachers prior to the treatment on a rating scale as either "normal" ($N = 78$) or "deviant" ($N = 85$). Results of the study demonstrated that the class meetings influenced self-concept somewhat, but had little influence on locus of control. The only significant changes in locus of control occurred in experimental students who had been rated as "deviants" by their teachers. Students in the normal group accepted responsibility for failure much more than did the deviant-rated control students. The author concluded that, in general, the open-ended class meetings were of little value in effecting change in self-concept or locus of control.

Rosario (1973) measured the effects of reality therapy group counseling on college students by means of the Nowicki-Strickland Internal-External Scale. The author predicted that extremely external students would show very little change of control orientation, extremely internal students would become slightly less internal, and moderately internal-external students would benefit most from class meetings. A pretest

and posttest model, with a follow-up testing 5 months after completion of treatment, was used. Results of the analysis of data for the initial posttest indicated that no significant shift was found for high internals, high externals, or those rated moderately internal-external. After the 5-month follow-up, results indicated that extremely external students did shift toward a more internal stance. The author thought that the change in locus of control for the external males may have been the result of attitude change based on the practice of the behaviors. The study had a number of shortcomings, including the absence of quasi-experimental and control groups. In addition, the use of 10 therapists allowed for uncontrolled variability in application of reality therapy techniques.

English (1970) also focused on the use of reality therapy (counseling) in various school environments. He demonstrated that reality therapy was an effective method for reducing disciplinary problems, increasing school achievement, and improving teacher-teacher and teacher-student interactions.

Marandola and Imber (1979) evaluated the effects of classroom meetings on the argumentative behavior (verbal and physical) of 10 preadolescent, inner-city, learning-disabled children. Both open-ended and problem-solving classroom meetings were used. During the intervention period, classroom meetings were used daily for 8 days with the focus always related to argumentative behavior in the classroom. Three types of behavior were used for analysis: (1) verbal argument between two classmates, (2) verbal argument involving two or more classmates, and (3) physical confrontation between two classmates. The results of the study provided strong support for the classroom meeting and its role in behavior change. Appropriate behaviors for positive interactions were maintained, and inappropriate argumentative behaviors were sharply decreased as a result of the class meetings. The study had some limitations: 9 of the 10 children had been with the teacher for 2 years, and strong rapport had been established between teacher and students. The children were also accustomed to having discussions, although they were not the same as Glasser's class meetings.

Poppen and Welch (1976) utilized reality therapy with 16 overweight adolescent girls who volunteered to participate in a weight-loss program. The subjects were evaluated by pretesting and posttesting with a self-concept scale. The treatment program lasted for 6 weeks. The results of the study indicated that reality therapy was effective in producing a significant weight loss; however, no significant changes in self-concept were detected.

Hough-Waite (1980) compared the effectiveness of the Parent Involvement Program with a behavioral program entitled the "Art of Parenting." A group of untreated controls was also included. Participants in treatment groups were 19 randomly assigned parents who volunteered to participate in a parent education group. Eight were assigned to the Art of Parenting Program, and 11 to the Parent Involvement Program. The control group consisted of 14 parents randomly selected from a large population.

A Child-Rearing Practices Questionnaire was administered before and after training, which lasted 6 weeks. The results indicated that neither treatment group differed significantly from the controls or from each other. Some factors could have confounded the results, including small sample size, lack of a sensitive outcome measure, and the use of volunteers as subjects.

Bigelow and Thorne (1979) compared client-centered and reality therapy techniques in group counseling at the elementary school level. One group contained six children and the other eight. All children were volunteers for a summer remedial reading program. Six group counseling sessions were conducted with both groups. The Hill Interaction Matrix was administered before and after the six sessions. The results indicated that the reality therapy group performed more efficiently than did the client-centered group in that significantly more therapeutic group member interactions were elicited by reality therapy techniques. It was also concluded that a counselor can direct an elementary-school age group into defined work areas and maintain it there more rapidly using a reality-oriented counseling approach.

Baskin and Hess (1980) conducted a review of seven affective education programs, one of which was *Schools without Failure*. In the area of self-esteem, the authors cited a 2-year evaluation of *Schools without Failure* in Grades 1 through 6, which found no significant impact on self-esteem but did find that the frequency of discipline referrals to the principal decreased with the implementation of the *Schools without Failure* program. It was also reported that no differences were found between treatment and control group achievement levels. The authors also discussed the methodological difficulties inherent to evaluating a program such as *Schools without Failure* and reality therapy.

Omizo and Cubberly (1983) studied 60 learning-disabled students, aged 12 to 24, who were assigned to experimental and control conditions. The students in the experimental group were exposed to discussions (e.g., obstacles to academic success) by teachers trained in reality therapy. Multivariate analysis revealed that the students in the experimental group attained higher academic aspirations and lower anxiety levels than those in the control group.

Yarish (1986) studied 45 male juvenile offenders (aged 12 to 16 years) to determine whether positive perceptual changes could be brought about by the application of reality therapy. The Nowicki-Strickland Locus of Control Scale for Children was administered to subjects during their first and last week in a treatment facility. A significant difference was found between the treatment and control groups. The subjects who received reality therapy moved in an internal direction and chose to behave better with control of their fate in their own hands. Subjects were treated for an average of 4 months.

Hart-Hester (1986) studied five fourth-grade students who exhibited behavioral problems such as noncompliance, aggressiveness, off-task behavior, and absenteeism. She tried to improve several targeted behaviors (i.e., on-task behavior, peer interactions,

and student-teacher interactions) through the use of reality therapy. Using anecdotal reports from the school principal, classroom teacher, and independent observation by investigation, the data indicated that reality therapy increased on-task behavior but not peer interactions or student-teacher interaction.

Tamborella (1987) investigated how troubled adolescents responded to the use of reality therapy procedures in a structured alternative school environment. Twenty students and six staff members were involved in the study. Evaluation was accomplished by using in-depth interview schedules, student permanent records, student attendance reports, student suspension reports, and the Statements about Schools Inventory. The results indicated that the use of reality therapy techniques that govern the types of student-teacher interactions in the alternative school program are effective in producing increased attendance and decreased rates of suspension. Students and staff experienced positive changes in self-perception, and students had positive perceptions regarding personal and academic needs satisfaction. It was demonstrated that significant and positive change in students and staff can be brought about through the impact of reality therapy.

Gorter-Cass (1988) evaluated an alternative school for disruptive junior high school youth. Program staffs were trained in reality therapy techniques. The results indicated that the initial steps of reality therapy were successfully delivered. Significant changes were found in identity, personal self-worth, family-self, and total self-concept. The later and more specific steps of reality therapy dealing with assuming responsibility and planning and carrying out behaviors were not successfully carried out. The behavioral outcome goals established by the steps of reality therapy were not achieved. However, a trend toward less severe behavior was demonstrated.

Bean (1988) investigated whether reality therapy could produce significant positive outcomes with community-based, male juvenile offenders. Changes were measured by recidivism rates and locus of control. The Nowicki-Strickland Locus of Control for Children was used to measure locus of control. Seventy-two offenders, aged 14 to 17, were randomly assigned to reality therapy, community service, Crossroads, or probation conditions. The recidivism rate for reality therapy was significantly lower than the recidivism rate of the Crossroads condition. There were no overall significant differences between groups or pretest or posttest locus of control measures. However, the reality therapy group demonstrated significantly more internal locus of control than the Crossroads group on an individual posttest pairwise comparison. The study concluded that reality therapy was the most effective in reducing recidivism rates. Reality therapy also appeared to affect locus of control significantly.

A study by Allen (1990) examined the efficacy of group counseling using reality therapy and a study skills program with at-risk students in the fifth and sixth grades. The children were evaluated on general self-esteem, behavioral academic self-esteem,

grades, and attendance. Ninety children from two elementary schools were assigned randomly to one of three groups: (1) reality therapy ($N = 30$), (2) study skill ($N = 30$), and (3) no treatment ($N = 30$). The groups were seen for 45 minutes twice a week over a 6-week period. Pretest and posttest measures included the Coopersmith Self-Esteem Inventory, Behavioral Academic Self-Esteem Rating Scale, academic grades, and attendance rates. There were no significant results for general self-esteem, academic grades, and attendance between reality therapy and study skill treatment groups. There was also no significant difference in the outcome of the four measures between the treatment groups and the control group. The reality therapy group failed to demonstrate a significant effect at the end of the 6-week treatment period.

Coats (1991) studied the impact of reality therapy on teacher attitudes and the behavior of emotionally disturbed children. Thirty-three students (aged 5 to 14 years) with severe emotional and behavioral disabilities, who were attending a special school, were used in this study. The children's behavior was measured by using staff interviews and examination of student behavior logs for the 1991/1992 school year. The findings indicated that reality therapy contributed in reducing the frequency of severe student behaviors. The majority of teachers interviewed perceived reality therapy as having a positive impact on student behavior. For example, seclusionary time-outs showed a marked reduction over the school year.

Harris (1992) assessed the use of reality therapy as part of an adolescent pregnancy prevention program. Two groups of 27 students were randomly selected to participate in the study. One group received reality therapy-based instruction whereas the other group served as the control. Measures of self-esteem, locus of control, and decision-making skills were used as predictors of responsible behavior. There was a significant increase on self-esteem for both groups with no significant difference on locus of control. Students who participated in the reality therapy group were able to distinguish between responsible and irresponsible behaviors. Most of the students reported that the reality therapy approach was beneficial in helping them choose responsible behaviors.

The purpose of a study by Kunze (1992) was to determine whether group counseling would improve the achievement (grade-point average), self-concept, and locus of control of students in an alternative educational program. Sixty-six ninth-grade students were assigned on a random basis to a treatment or control group. Subjects in the treatment group participated in ten 45-minute group counseling sessions over a 4-month period. Reality therapy techniques were used with an emphasis on goal setting, decision making, and problem-solving skills. There were no significant findings to support group counseling using reality therapy.

Block (1995) studied the use of reality therapy in small group sessions to improve the self-concept of fifth- and sixth-grade students. The students were placed in two treatment groups each led by a different group leader. There were seven students in each group.

The groups met for six 45-minute sessions over a 6-week period. The basic principles and techniques of reality therapy were used to enhance self-concept. A control group was also included in the study. The Piers-Harris Children's Self-Concept Scale was given before and after treatment to all three groups. The results indicated reality therapy, when applied in small group sessions, was effective in increasing the overall self-concept of upper elementary aged students. It was also found that using different group leaders had no significant effect on the outcome for the two experimental groups.

Wicker (2000) conducted a study to determine if significant differences existed in the reported menstrual distress of African American high school females who received reality therapy counseling as compared to females who did not receive treatment. The 49 participants were 11th- and 12th-grade students from a small, inner-city school. Menstrual distress was measured by the Menstrual Distress Questionnaire (MDQ). The study was a quasi-experimental one utilizing a pretest-posttest control and treatment group design. The treatment group participated in an 8-week curriculum using reality therapy group counseling. The sessions focused on the students' total behaviors such as thinking, acting, feeling, and physiology. An ANCOVA was run on adjusted posttest MDQ scores with no statistical differences. Both groups reported reductions in menstrual distress, however, when the differences in pretest and posttest scores were analyzed for each group, neither group showed significant gains.

Lewis (2002) investigated whether a course that was based on reality therapy impacts classroom teachers' perceived effectiveness in responding to disruptive behavior. Information was collected by using a survey with three groups of teachers who had completed a course in reality therapy and had implemented the techniques of reality therapy in their classrooms for at least a year. The results indicated the majority of teachers felt more confident about their ability to develop their own proactive discipline program. The author concluded that teachers who have received training on reality therapy have more confidence in dealing with students who have disruptive behaviors. The teachers also noted improvement in student behavior and attendance. However, the study lacked a control group and only reported percentages with no statistical information to back up the claims the teachers made.

A study by Petra (2001) evaluated the effects of a choice theory and reality therapy parenting program on children's behavior as measured by the Behavior Assessment System for Children (BASC), Parent Stress Index (PSI), and behavior referrals (BR) to the school counselor. Parents were included in the study if (a) their child was referred to the school counselor three or more times for one or more of the following: defiance, unsafe behavior, property damage, and verbal and physical abuse toward others, and (b) they requested to be in the study. Forty-five parents from one elementary school were randomly assigned to one of three groups: Group 1 received 13 hours of the parenting program with reality therapy in individual sessions; Group 2 received 13 hours of

the parenting program with no reality therapy in group sessions; and Group 3 received no special materials or therapy. The groups were analyzed using an ANOVA and Bonferroni Test of Multiple Comparisons. The results suggested that both programs improved the children's behavior at home and at school. The 13 hours was sufficient time to significantly improve children's behavior.

Yarbrough and Thompson (2002) researched the efficacy of reality therapy with elementary school children engaging in off-task behavior. The participants were two children from a suburban elementary school. One was an 8-year-old African American male who was in the third grade and a 9-year-old Caucasian female enrolled in the fourth grade. Specific goals related to classroom behavior and assignment completion were developed for the study. Goal attainment scales were used to track the students' progress relative to their baseline rates on completion of their assignments. An AB design was used with goal attainment scaling which included repeated behavior measurements in a time-series format over 8 weeks. Baseline data were gathered during the first 3 weeks of the study followed by 5 weeks of the treatment phase. The results supported reality therapy for working with off-task behavior. The initial baseline scores were well below the mean score of 50 for goal attainment scaling. It appeared that reality enabled the two children to set specific goals, track their progress, and experience a positive change in behavior and in their classroom performance. The authors reported that one child's final score was 75 and the other's 66.

A study by Harvey and Retter (2002) compared the profiles of 402 children and adolescents age 8 through 16 on the Basic Needs Survey, which measures the relative strength of Glasser's four psychological needs (i.e., control and power, fun, freedom, and love and belonging) for variations by gender. Results indicated that adolescents expressed a significant higher need for Love and Belonging, and a significant lesser need for Fun than young girls. Adolescents expressed a higher significant need for Freedom and a significant lower need for Power and Control than latency-aged children. The results of this study demonstrated that developmental and gender differences in drives to meet the basic psychological needs depicted by Glasser need to be taken into consideration for therapy and curriculum planning.

Passaro, Moon, Wiest, and Wong (2004) studied whether several measurable behavioral changes would occur as a result of the use of reality therapy and an in-school support room. Ten males in grades six through eight participated in the study. Each student met the State of California Education Code criteria for an emotional disturbance. The variables evaluated were positive changes in average daily behavior over a school year; reductions in the number of out-of-school suspensions compared to the previous school year; and increases in the number of times students participate in general education courses compared to the previous school year and within the current school year. The daily behavior of students in the study was assessed using a 4-point Likert scale.

Behaviors typically included were, compliance, task completion, and verbal/and or physical aggression. The results provided positive indicators for the use of reality therapy and the in-school support room. In general, the average daily behavior ratings improved on average by 42% over the school year. At the start of the school year, average student behavior assessed by staff as being in the lowest range 36% of the time, while average student behavior reached the highest level (excellent) only 19% of the time. However, after one semester this trend was reversed. At the end of the school year, average student behavior was assessed in the highest range 38% of the time, while average student behavior was reported in the lowest level (poor) only 13% of the time. The amount of time spent in general education increased to over 62%. The out-of-school suspensions decreased by 12% from the previous school year. However, there was no control group, only percentages were reported, and the number of participants was small.

Lord (2005) studied the effect that choice theory/reality therapy would have on increasing high school students' perceived satisfaction in the four basic principles of reality—belonging, power, freedom, and fun—and how these needs affected behavioral change. A quasi-experimental, nonrandomized pretest/posttest design was used. For five sessions, the treatment group received information about the principles of choice theory. After the first posttest, the control group also received information about choice theory. A second posttest was administered to each group. A 2 × 3 repeated measures ANOVA was conducted on all the data of the 4 psychological needs after the second exposure. Significance was obtained on students' perception of needs in three of the four psychological needs. Interviews were conducted with students from the treatment group, whose satisfaction scores significantly increased at the .05 level, in at least one of the four psychological needs. The interviews suggested that exposure to choice theory principles influenced the student's perception.

Hale (2011) examined if 42 second grade students who were taught by teachers trained in *choice/reality therapy techniques* would score higher on achievement scores in mathematics/reading when compared to 42 students who were taught by teachers who were not trained. An ANOVA was conducted to measure the main effect of achievement in mathematics/reading and training status of teachers. There was no significance found between the two groups of teachers. The teacher training was only 6 hours and the study did not offer follow-up training.

The purpose of a study by Austin (2013) was to examine the influence of Effective Teens training on the attendance, discipline referrals, and academic achievement of 10th grade students. The theoretical framework of the study was choice theory, which uses reality therapy as its basic method. The study included 96 Grade 10 students in one rural high school that involved a 3-week counselor-led program. A pre- posttest control group design was used to determine if there was significance between the

treatment and control groups on discipline referrals, attendance, and achievement. An analysis of covariance indicated there were significant differences in outcomes based on the treatment.

The results discussed in this section that dealt with actual research studies included 33 articles or theses. In fact, the majority were doctoral dissertations. The articles that were in journals were mostly from the *Journal of Reality Therapy*. Most of this research has been done with group or class meetings. These findings indicated mixed results for self-concept, achievement, and locus of control. However, a number of the studies showed significant decreases in behavior problems.

There were 14 studies that used reality therapy in a counseling or classroom situation rather than as part of a class meeting. These studies demonstrated that the therapy process significantly decreased behavioral problems, aided weight loss, increased attendance, lowered recidivism, and decreased rate of suspension. The findings were contradictory for self-concept, locus of control, and achievement.

The preceding studies share the usual methodological problems encountered when the effectiveness of therapeutic approaches is evaluated. It is very difficult to measure items such as involvement, happiness, fulfillment, and successful identity.

The four greatest problems in evaluating reality therapy, class meetings, and other therapies are the following, as discussed by Baskin and Hess (1980):

1. The use of more than one teacher or therapist in either the program or control groups.
2. Difficulty in assessing goals because of the complexity of the behaviors to be evaluated. The measures used to evaluate outcomes are not sensitive enough to detect changes that occur as a result of treatment. Bernal and North (1978) suggest that multiple outcome measures, including objective measures of changes, should be used. In addition, the construct validity of self-concept and of locus of control has not been established.
3. The use of testers who do not know the purpose of the evaluation and identity of treatment and control groups.
4. The usual problems of self-evaluation research, including both the tendency of some subjects to answer questions in a socially desirable manner and the amount of self-disclosure a subject is willing to give to a self-report inventory.

In addition, most of the studies reviewed here utilized small sample size and relatively brief training periods. Also, the amount of time available for actual behavior change to take place is a limitation, because usually several weeks or more need to be spent developing student-teacher or therapist involvement and group cohesiveness. How much experience one has had in the therapeutic technique used is also a variable.

There is little question that reality therapy has directly or indirectly inspired many individuals and schools. Numerous testimonies and endorsements have been made, but most applications of the therapy have not been subjected to any kind of formal research program.

The limited research with class meeting and reality therapy counseling does lend some support to its effectiveness in areas such as discipline and lends little support in other areas such as self-concept. Additional research to deal with some of the evaluation problems raised in this discussion is necessary for substantiating the validity and usefulness of the reality therapy/choice theory concepts and principles.

CONCLUSION

Reality therapy is based on a common sense philosophy that can be used by trained persons in many situations. These persons include the teacher in the average classroom, those involved in corrections and mental institutions, clinicians, and parents.

Responsibility is a basic tenet of reality therapy. It is thought that an assuming of responsibility will lead to a heightened sense of self-worth or self-respect and a greater sense of freedom, both of which may, at the same time, help the person experience better relationships and more fun in life.

Reality therapy emphasizes the rational and the cognitive. Clients are asked to describe their behavior specifically and to make a value judgment concerning its effectiveness. A specific plan to alter a concrete behavior is then drawn up, and a commitment to follow that plan is elicited from the client. Praise is given for success; no excuses are accepted nor is punishment given for failure. Although this approach appears almost simplistic, its success is dependent on an honest and thorough commitment on the part of the therapist to maintain concern and effort in the face of continued failure. As W. Glasser (1965) wrote:

> [the] practice [of] reality therapy takes strength; not only the strength of the therapist to lead a responsible life himself, but also the added strength both to stand up steadily to patients who wish him to accede to their irresponsibility, and to continue to point out reality to them no matter how hard they struggle against it. (p. 23).

Testimonials and informal surveys indicate that reality therapy has a positive effect on clients and situations, but new and better approaches to definitive research must be sought. Future research designs must include explicitly defined control and experimental groups and the use of reliable and valid criterion measures.

Reality therapy requires time to be effective. Future research should be oriented toward longitudinal studies of a year or more, and the shorter-term studies must include

more sessions and subjects if one hopes to measure impact. Use of a formal behavior rating scale, test, or coding instrument to measure the actual behavior change of the client from pretreatment to posttreatment is recommended. It may also prove fruitful to develop an empirical observation system that could help validate the degree to which reality therapy techniques are actually being implemented in the classroom.

Reality therapy focuses on freedom, not license. With loving firmness and respect, the child is led away from irresponsibility toward the responsibility and concomitant self-respect that come with true freedom and a successful identity.

Case Study

John, age 10, was referred by his parents at the request of the public school system because of his continued refusal to talk. The difficulty manifested itself in kindergarten, and by the end of third grade, he had become a legend in the school system with a multitude of school personnel eager to take on the challenge of making him talk. The previous year he had been diagnosed as having elective mutism and as manifesting anxiety, social withdrawal, and depression both at school and at home. He was passive and withdrawn when confronted with the usual sibling onslaughts from his two brothers and two sisters, and he did not play with the neighbor children. At age 10, he was still an occasional bed wetter. His mother characterized him as a good boy who was quiet and reserved, who entertained himself well, and who enjoyed playing alone.

Initially, John appeared tense, stiff, immature, and sensitive. He lowered his head to avoid eye contact, and if the situation became too stressful for him, he began scratching his arm and cheek. He was fearfully shy and refused to speak. A beginning relationship was formed with him through playing games, going for walks, or getting some candy at a nearby store. As he gradually relaxed, he began to smile and laugh a bit during the sessions, but when asked a question, he would only shake his head or occasionally write his answer on a piece of paper.

As the relationship became stronger, he was told that he and the therapist would no longer play for the entire hour. Instead, he was told they would talk or sit together for the first 15 minutes. When he came for the next session, this plan was initiated. He was questioned about his happiness and unhappiness and about events at home and at school. Although he did not not speak, he nodded yes that he was unhappy. The problem behaviors that his parents and the school said he was engaging in were stated, and he was asked for his opinion. These behaviors included not talking in school, having no friends, crying a lot, and receiving poor grades. These were written on a piece of paper, and he was asked to check the ones that he agreed with. He checked not talking in school and having no friends. With several of his problem behaviors out in the open, he was asked if they were making him unhappy and if he wanted to do something about them. He nodded. Although some behaviors were identified and a value judgment made

by John, he was not yet ready to do something about them. Attempts to elicit a plan from him resulted only in a lowered head and a shrug of his shoulders. At this point, more strengthening of the relationship was needed, and the sessions continued with the initial 15 minutes reserved for conversation. Initially, the therapist talked and John nodded when possible or else they sat in silence. On occasion, the therapist would ask a question and then answer it for him in a manner he wouldn't like. This action made John uncomfortable but did not elicit any speech. The sessions began focusing on his refusal to speak at school. He indicated that he wanted to talk, that he understood that it was important to do so, that he realized his not talking might result in his failing for the year, and yet he refused to speak.

As the relationship grew stronger, it became more threatening to John. He had begun to initiate some silent mouthing that indicated at least some desire to talk. He was now faced with giving up his symptoms. An occasion when the therapist called John's home added to this pressure. Expecting the mother to answer, the therapist was surprised to be greeted by a loud male child's voice. It was John's. At the next session, John was confronted with the phone call. John smiled but did not respond. At this point, the therapist tested the relationship by pointing out that John had been coming for 2 months but that he was contributing very little, and perhaps they should consider termination. He was told to think about these things and that they would pursue the subject at his next session. He agreed to this with a nod of his head.

On his next visit, John appeared more uneasy than usual. He started the session by indicating that he wanted to play. This proposal was countered by the therapist's saying that last week's problem had to be discussed. After a brief review of the problem and reconfirmation of John's value judgment, he was asked to talk. Again, he refused. In an attempt to force the issue, the therapist suggested that John's mother be called and told that they were terminating. John sat still for several minutes before nodding his head in consent. The therapist immediately said he decided against it, changed the subject, and took John to play. The rationale behind taking a chance was the risk that the involvement was great enough to keep John from terminating. Strong as it was, however, the involvement was not yet sufficient to help John replace his problem behavior. So with this in mind, the therapist backed off and continued to be friendly and interested in John. Therapy is based on a relationship, and there are times in every relationship when one loses face or gives ground. Frightening as it might have been for the therapist, his move demonstrated to John the important lesson that one can be strong without always being in control.

For the next month, John's presenting problem was avoided and the involvement was focused on. His nonverbal interaction increased and he was more relaxed, laughing, and appearing content. At the end of this month he was once again asked what he was doing and whether it was doing him any good. He seemed quicker to agree to his

symptoms and to indicate that he was not pleased with them. While joking with him about hearing his voice on the phone, the therapist had the thought that John might talk into a tape recorder. John indicated he would not. He was asked if he would take the recorder home, talk into it there, and then bring it back the next time. He agreed to this, and they shook hands on the plan. He did not, however, follow through. Rather than preaching, the therapist indicated to John that he had not carried out the plan as agreed, and John was asked if he wanted to try again. He indicated that he did, and the following week, he arrived with the tape, gesturing to have it put on the recorder, which the therapist did. In a whispered tone came the word "Hello." John was praised a great deal for his feat. Over the next several sessions, John continued to make tapes at home and bring them to each following session. John's responses on tape were eventually enlarged into whispered sentences. Each of John's efforts was reinforced, and the therapist often asked him if it felt good to have accomplished this. Always John would smile and nod yes.

But it was time now to move on, and during the next session, it was again indicated to John that he would have to start talking aloud, that using the tapes was a good start and an indication that it was not so bad to talk. It was emphasized that it was time for John to demonstrate his contribution to the relationship and to talk because the therapist had been doing most of the work. "Please say 'Hi'," the therapist said. There were several minutes of silence and finally, with great effort and initial mouthing behavior, John said "Hi" in an audible whisper.

This was a special moment for both of them, and it was followed by much praise. On leaving, John whispered, "Good-bye." This incident impressed again how necessary a strong involvement is in therapy and how critical it is in effecting change. How much it must have taken John to say those words!

Expectations for the next session were quickly lowered when John sat and said nothing during the beginning of the hour. Asked if he would talk aloud, he shook his head no. Reminding him of the progress from the last session and the triumph of his success, the therapist asked John whether he would talk if the therapist turned his back to him. He nodded yes and they shook on it. The therapist turned his back and looked out the window. About 5 minutes passed before John spoke loudly enough to be heard. The therapist, continuing to sit with his back to John, then asked him several simple questions and received the answers. Then they talked about John's success during his session, with a lot of praise being given. A plan was made to continue this approach for the next couple of sessions. A written commitment was made. The plan was carried out, with John talking to the therapist in a whisper while the therapist sat with his back to John.

After two sessions, a plan was made that they would talk face-to-face. When John arrived for the next session, he was more uneasy than usual. He sat down and the therapist said hello. About 2 minutes of silence followed before John whispered "Hi."

They talked about what he had watched on television and what he had done on the weekend and in school, with John responding in whispers. This continued for several sessions, and the therapist then asked him what could be done to help him talk in his normal voice. At first John shrugged his shoulders, but then he said, "Talk louder." This became his responsibility for the next session. At the next meeting, John fulfilled his commitment; he and the therapist talked for approximately 30 minutes.

After this meeting, each session lasted for about 45 minutes, and they were able to talk for the entire time. Up until this point John's not talking in school had not been discussed. It was important for him to get used to talking in his "loud" (normal) voice over a period of time in order to break his old habit of getting by without speaking. At a certain point, however, it was hoped that John might be able to generalize his success. Consequently, John was asked if the therapist could call his teacher to check on his school progress; John agreed. The therapist learned that John was not talking in the classroom.

At the next session, the therapist asked John if this was true and John said it was. When the subject was pursued, John said he did not want to continue not talking in school. He was asked what his plan would be, and he said he would talk to his teacher. The therapist indicated that the plan wasn't quite clear in terms of how, when, and where. After some discussion, it was decided that he would talk to the teacher on Tuesday and Friday mornings. When asked what he would say, he indicated that he would say hello and ask to go to the bathroom instead of just raising his hand. The plan was written up and signed, with each of them receiving a copy.

When John came back the following week, he indicated that he had carried out the plan. Over the next several sessions, they worked on increasing the number of days and the things he would say. Indeed, everything seemed to be progressing even better than expected. Each time a plan was formulated; a commitment was made and executed. A phone call from John's mother, however, changed all that.

John's mother called, saying that she had just returned from a parent-teacher conference and was told that John was not talking at school. This news was an eye-opener because previous contacts with her had been encouraging; she indicated earlier that John was talking more in the neighborhood and in the local stores. John, it turned out, had been telling both his mother and the therapist that he was talking in school when, in fact, he was not. The therapist had taken John's word, which on the surface seemed to be the thing to do because a good relationship existed. But John had learned to keep the therapist off his back by quickly setting up a plan and then indicating that he had carried it out.

The next time John came to therapy and indicated that he had executed his plan, he was asked if he had any objection to the therapist's calling his teacher to ask how he was doing. He said yes. When the therapist asked what the objection was, John replied

that it was not necessary to call the teacher, that he was reporting everything that was happening. The therapist expressed doubt and told John about his mother's phone call. John admitted to not having talked in school and started to make excuses for his lack of success. He was immediately interrupted and asked if he wanted to talk in school; he said he did. Plans similar to the ones used before were then formulated, with the further stipulation that the therapist would call the teacher each week to check on how John's plan was working. The therapist told John he was very much interested in John's talking progress in school and also in knowing how the teacher perceived the progress and whether this progress was the same as he, the therapist, thought it was. John agreed to this additional plan.

To coordinate their efforts, the therapist saw the teacher before the next session. She was cooperative and interested in helping in any way possible. She was informed of John's progress to date and of some of the techniques that were being used with him. She agreed to read some literature on reality therapy and carry out some suggestions. The need to praise John's talking and the consequences to be used if the rules were not followed were particularly emphasized.

John was told that what took place at this meeting between the teacher and the therapist and what could be expected. It became evident that John was much more likely to talk if he went up to the teacher's desk. They started with this approach, and soon he was doing this at least once a day. John would walk to the teacher's desk when he had a question, and later, the teacher would also ask him questions. Eventually, plans were also made and carried out whereby John talked to his gym and music teachers. Again, he was able to communicate with them in a whisper.

During this period, John was strongly regarded for his successes, and his feelings of self-worth appeared to increase. He would now admit that school was a better place than before and that he did enjoy it more. John and his therapist discussed John's talking louder and also talking from his desk, but he was still not willing to make a commitment to either of these actions. At this point the school year had ended, and because of a number of scheduling problems and summer programs, it was decided that there would be no more therapy sessions during the summer. It was agreed that John's mother would contact the therapist in the fall if things were not going well for him.

In the beginning of October, John's mother called and indicated that John had regressed in school and that he wanted to come for therapy. The mother attributed this regression in part to his new teacher, who was older and more authoritarian than the previous one. She reported that he had had a good summer, that he talked to others outside the home, and that he was less shy and more outgoing.

The therapist and John were able to pick up and begin pretty much where they ended in the spring. John was still talking in a loud voice to the therapist and, in no time at

all, in a whisper, once again, to the teachers. In a short time, the therapist was able to elicit a value judgment and a commitment from John that he wanted to talk out loud in school. It was agreed that John would speak with the teacher alone at her desk. It was also established that if the plan was not carried out, John would have to miss recess. Because he understood and agreed to the outcome before he engaged in the activity, missing recess was seen as a logical consequence of his behavior, not as punishment. When he did not talk out loud to his teacher at her desk for the first time, he missed recess. At the same time, it was stipulated that he would have to come up with a plan so that not talking aloud and missing recess would not happen again. His plan was to try it once more with a specific sentence to say, which turned out to be, "Can I have my math assignment?" This time it worked for him. At this point, he and his teacher agreed to his doing this at least three times a week with the days being his choice. The plan was accomplished, and within a short time John was saying something out loud at least once a day. Because the teacher was working so well with him, John and the therapist agreed to meet only twice a month.

There were ups and downs during the school year, but overall John continued to improve. Toward the end of school, John was beginning to talk out loud from his desk, but this activity was still somewhat troublesome for him. The therapist agreed to continue to see him during the summer once a month to help him prepare for a new teacher and grade. In the last several sessions he talked "a blue streak." He was spontaneous, showing no shyness, and was much more confident of his own ability to perform. They went to a store to buy candy and there he asked the clerk several questions and responded to a question asked of him. John and the therapist also talked about alternative strategies and choices—he agreed to talk out loud from his desk when school began in the fall, and he appeared confident about doing so.

During the course of therapy, the therapist repeatedly emphasized that he was interested in John's dealing with the present, particularly in John's attempts to succeed and to deal with his problems in an effective and responsible manner. With John, it was necessary that he be assured that the therapist would stick with him until his problem was resolved. To this extent, the relationship played a major role. When John resorted to "I can't," in discussing certain situations, the therapist converted "I can't," to "You don't want to or you mean you won't—let's explore the choices you have." Until the two were involved and until John realized that he was responsible for his own behavior and that something could be done about his problem, little progress occurred. Through the involvement, he finally realized that he was responsible for his talking. In this way, he was helped to understand his capacity for more worthwhile behavior in his immediate environment. His decisions to become involved, to change his behavior, and to continue talking were the essence of therapy.

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In this book, 25 case histories by therapists who have received certification from the Institute of Reality Therapy are presented. The cases were selected to show as many different kinds of problems as possible. The cases are so varied that anyone using the steps of reality therapy should be helped toward a better understanding of how the steps work in practice. Eight of the cases deal with children and adolescents.

Glasser, N. (Ed.). (1989). *Control theory in the practice of reality therapy: Case studies*. New York, NY: Harper & Row.

Glasser examines control theory's role in the practice of reality therapy through case studies. These case studies provide interesting examples of ways that control theory can be translated into the practice of reality therapy. The cases are detailed enough so professionals can learn more about how control theory and reality therapy can be applied together.

Glasser, W. (1969). *Schools without failure*. New York, NY: Harper & Row.

The concepts of reality therapy as applied to the schools are presented here. Many school practices are described that promote a sense of failure in the student, and suggestions are given for correcting these practices. The three types of class meetings are presented with numerous topics that could be used for each one.

Glasser, W. (1986). *Control theory in the classroom*. New York, NY: Harper & Row.

The author provides a useful analysis of what is wrong with traditional schooling and what needs to be done. The book translates control theory into a classroom model of team learning in the schools. Numerous ideas are given that will contribute to the success of classroom teachers. The book discusses discipline problems and learning team models.

Glasser, W. (1998). *Choice theory: A new psychology of personal freedom*. New York, NY: HarperCollins.

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Wubbolding, R. (1991). *Understanding reality therapy: A metaphorical approach*. New York, NY: Harper & Row.

Professionals will find a detailed presentation of the principles behind control theory and the techniques of reality therapy. Metaphors, analogies, and anecdotes are used in a clear, concrete, and brief style that enables the professional to develop applications for clients. Also included are conversations with patients and questionnaires that help analyze feelings and how to take better control of one's actions.

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CHAPTER

8

Solution-Focused Approaches

JOHN J. MURPHY

> You can't solve a problem with the same type of thinking that created it.
> —Albert Einstein

In a classic article from the business literature, Levitt (1975) describes how various industries failed when they became product-oriented rather than consumer-oriented. Railroad leaders in the mid-20th century scoffed at the possibility that air travel might eventually become a key player in the transportation business. Heads of the major movie studios were similarly caught off guard by television because they wrongly saw themselves in the movie versus entertainment industry. When television was first introduced, movie mogul Darryl Zanuck claimed that it would not last beyond 6 months because people would quickly tire of sitting in their living rooms and staring at a tiny box every night (Lee, 2000). This arrogant lack of foresight eventually forced the bankruptcy and closure of once-powerful movie studios.

We can fall into a similar trap as psychotherapists and counselors by acting like we are in the therapy business rather than the business of helping people change. Regardless of theoretical orientation, all therapists need to prioritize the consumer-driven goal of helping people change over the model-driven goal of maintaining theoretical purity (Wachtel, 2011). With these points in mind, this chapter describes solution-focused approaches to counseling and psychotherapy with children and adolescents. The terms *therapy* and *therapist* are used throughout the chapter for the sake of simplicity.

The chapter begins with an overview of the history and theory of solution-focused practice. The theory section includes a description of its basic assumptions and views on psychopathology, followed by general therapeutic goals and interventions. While most

of the discussion and examples involve individual therapy, other uses of solution-focused practice are also covered such as group work and educational applications. The chapter concludes with a discussion of research on the effectiveness of solution-focused approaches, along with a short client example involving an adolescent client and her parents. The acronym "SF" will occasionally be used for "solution-focused."

HISTORY AND STATUS

Solution-focused approaches originated in the family-based work of Steve de Shazer, Insoo Kim Berg, and colleagues at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin. Prior to his work at the BFTC, which was founded in 1978, de Shazer became familiar with the work of Milton Erickson while studying with family therapy pioneers Jay Haley, Virginia Satir, and John Weakland at the Mental Research Institute (MRI) in Palo Alto, California—the place where he met future BFTC co-founder and wife Insoo Kim Berg. Berg came to the United States from Korea in 1957. She was a gifted clinician who contributed substantially to the evolution of solution-focused thinking from its origins in the 1970s through her death in 2007. Berg and de Shazer, who died in 2005, were prolific writers and trainers who traveled the world to share the ideas and methods of solution-focused practice.

The term *solution-focused brief therapy* (SFBT) was coined in the 1980s several years after the Milwaukee group began meeting to discuss therapeutic issues and ideas. Inspired by the innovative work of Milton Erickson (Haley, 1973) and the Mental Research Institute (Watzlawick, Weakland, & Fisch, 1974), along with Gregory Bateson's writings on cybernetics and psychiatry (Bateson, 1972), the Milwaukee team launched a research and clinical program aimed at addressing the question, "What works in brief therapy?" The question itself reveals SFBT's historical interest in simplicity, efficiency, and practicality—an interest reminiscent of the pragmatic philosophies of William James and Ludwig Wittgenstein, both of whom espoused the practical benefits of identifying and describing "what works" to improve a situation instead of developing lengthy and complex explanations and interpretations of the situation.

Starting in the late 1970s, the Milwaukee team videotaped and analyzed thousands of therapy sessions in an effort to clarify what makes for effective therapeutic conversations—that is, *what do therapists and clients talk about when therapy is successful*? Instead of beginning with a specific theory or hypothesis, the team let the clients lead them to new answers and insights. Several standard SFBT interventions began as fortuitous interventions with an individual client (e.g., first session task, presession change question). If the same intervention worked well for other clients and other problems, the team would continue to use it and examine the results. The principles

and practices that proved most effective in helping people change evolved into the core assumptions and methods of solution-focused practice.

Postmodern thinking and social constructionism (Gergen, 1985) became increasingly important in SFBT's development, with emphasis on the constructionist idea that therapeutic conversations can alter and reconstruct the way clients view themselves, their problems, and their possibilities. This led de Shazer and colleagues to pay even greater attention to the words that transpire between clients and therapists and to the therapist's precise use of language and questions (Berg & de Shazer, 1993; de Shazer, 1988, 1994). They found that therapeutic dialogue had a powerful effect on outcomes and developed solution-focused interventions that encouraged a conversational shift from past-focused problem talk about clients' diagnoses and problem history to future-focused "solution talk" about their goals and possibilities.

One of the most intriguing discoveries of the Milwaukee team was that effective solutions did not require extensive knowledge about the problem—in fact, solutions often bore little resemblance to the problem. This finding challenged the long-held assumption that a thorough diagnosis is required for a successful solution. The team also discovered the benefits of following the lead of clients by asking for specific descriptions of what they want from therapy (client-driven goals), how they will know when they get it (client-driven criteria of goal attainment), and what they are already doing to help themselves reach their goals (successes and strengths). These methods not only made sense based on observations of countless therapy sessions, but produced favorable results in a shorter period of time—the "brief" aspect of SFBT.

By the mid-1990s, solution-focused therapy was routinely included in counseling and therapy textbooks under the category of postmodern approaches. As the approach gained greater international exposure in Europe, Asia, and Latin America throughout the 1990s and beyond, two professional associations—the European Brief Therapy Association (EBTA) and Solution-Focused Brief Therapy Association (SFBTA)—were established to promote research, development, and networking among SFBT practitioners and researchers. Although the BFTC in Milwaukee formally closed its doors in December of 2007, the ideas of SFBT live on through many therapists and writings that have modified the approach in various ways. Among the most popular modifications are solution-oriented therapy (O'Hanlon & Weiner-Davis, 2003) and strengths-based therapy (Saleebey, 2012). Variations of solution-focused therapy for children, adolescents, and school problems include brief counseling (Litrell, 1998; Sklare, 2004), change-oriented therapy (Bertolino, 2003), and student-driven interviewing (Murphy, 2013).

The increased visibility of solution-focused ideas throughout the world has been accompanied by a progressively wider range of programs, services, settings, problems,

and clients—including children and adolescents—to which the approach has been successfully applied. These applications include corporate coaching (Berg & Szabó, 2005), child protective services (Wheeler & Hogg, 2012), classroom management and teaching (Berg & Shilts, 2005), school-based intervention (Metcalf, 2010; Murphy, 2008), divorce (Weiner-Davis, 2001), substance abuse (Hendrick, Isebaert, & Dolan, 2012), schizophrenia (Panayotov, Strahilov, & Anichkina, 2012), sexual abuse and trauma (Dolan, 2000), self-harming adolescents (Selekman, 2009), and domestic violence (Lee, Uken, & Sebold, 2012).

The conceptual simplicity and hopeful stance of solution-focused approaches appeals not only to therapists and clients, but to paraprofessionals who are increasingly called on to implement services in group homes, schools, and other settings that serve children and adolescents. Refer to Lipchik, Derks, Lacourt, and Nunnally (2012) for additional information on the origins of solution-focused therapy.

OVERVIEW OF THEORY

This section provides an overview of solution-focused theory, assumptions, and views on psychopathology.

Basic Theory and Assumptions

Everything we do as therapists is influenced by our attitudes and assumptions about people, problems, and solutions. They guide decisions about what questions to ask, what to focus on, and how to evaluate the effectiveness of services. The theoretical ideas and assumptions of solution-focused practice have evolved from three decades of clinical practice, observations, and research on what works in therapy. The following assumptions are adapted from several sources (de Shazer et al., 2007; Franklin, Trepper, Gingerich, & McCollum, 2012; Murphy, 2008, 2013) and reflect the simple, practical emphasis on doing what works to help people change.

Collaboration enhances change. The quality of the client–therapist relationship—as perceived by the client—is strongly linked to therapeutic outcomes (Norcross, 2010; Orlinsky, Rønnestad, & Willutzki, 2004). Given that successful relationships are built on mutual respect and collaboration, it is no surprise that client involvement is the centerpiece of effective therapeutic relationships (Orlinsky et al., 2004). Solution-focused therapy is a highly collaborative approach that invites children and adolescents to participate in every aspect of their care from developing goals to evaluating services. People are more likely to implement ideas and interventions that emerge from their input and resources as compared to uninvited ideas that are imposed on them by therapists or others. "It is always best if change ideas and assignments emanate from the client, at least indirectly during the conversation, rather than from the therapist, because the client is familiar with these behaviors" (de Shazer et al., 2007, p. 5).

Unlike many therapy approaches, the concept of "resistance" has no place in solution-focused work because clients are always seen as cooperating with their own theories and perceptions. It is the therapist's job to structure services in ways that are sensible and engaging to the client. The motto of SF therapists is, "if you want people to cooperate with you, then you need to cooperate with them."

It is more helpful to focus on future solutions than past problems. In contrast to traditional approaches that spend considerable time diagnosing and discussing previous problems, solution-focused approaches invite clients to envision and specifically describe their preferred futures—that is, what they would prefer to be doing differently if therapy is successful and the problem is resolved. This assumption is based on the observation that clients often become discouraged by the problem and that lengthy conversations about its history, presumed causes, and other such matters can add to their discouragement.

Most clients welcome the opportunity to discuss what they can do to make things better rather than what they have done to make things worse. This does not mean that all discussions of the problem or the past should be avoided at all costs; to do so could invalidate the person's struggle and exclude potentially useful information. The approach is solution-focused, not solution-forced; it is neither problem-phobic nor past-phobic. There is a big difference, however, between discussing a problem in solution-focused ways and conducting intensive explorations and analyses of the problem.

Another aspect of this assumption that distinguishes solution-focused approaches from others pertains to the assumed relationship between problems and solutions. Whereas most approaches assume that there is a logical relationship between problems and solutions and that changes occur through a problem-leading-to-solution sequence, SF theory holds that effective solutions may have little or nothing to do with the problem.

Language shapes people's perceptions of themselves, their problems, and their possibilities. *What* we say in therapy and *how* we say it can powerfully shape people's perceptions of themselves and their possibilities (Wachtel, 2011). The power of dialogue in shaping perceptions has been confirmed by social psychology research (Fiske & Taylor, 2008), which suggests that clients' conversations with others—whether positive or negative—shape self-perceptions in ways that correspond to the discussion. When people are asked to reflect on problems and other negative aspects of their lives, they report lower levels of self-esteem and contentment than those who reflect on positive aspects (McGuire & McGuire, 1996). These findings suggest that the positive or negative wording of a question may affect not only its answer, but the way that children and adolescents subsequently think about the topic and themselves.

Solution-focused therapists distinguish between problem talk and solution talk (Franklin et al., 2012). Problem talk focuses on problem history, causes, and diagnosis; solution talk focuses on the client's goals, resources, and possibilities. Therapists provide the opportunity for clients to discuss their problems without becoming mired in problem

talk. This chapter describes various techniques for increasing solution talk and boosting students' involvement, cooperation, and hope.

Every client has strengths and resources that can be used to build solutions. This assumption urges therapists to approach clients from a hopeful perspective that honors their unique perceptions, resources, and experiences. Young people who struggle with serious problems often overlook small successes, strengths, and resources. They may not even realize that they have such resources, much less apply them, unless someone explicitly asks about them. For example, most children and adolescents have solved many problems in their lives, and their previous solutions may be useful in addressing their current concerns.

Therapists are alert to any signs of success and competency because these are the building blocks of therapeutic change in solution-focused approaches. More specifically, the therapist and client coconstruct alternative patterns of thinking and behavior by drawing on the client's existing repertoire of skills and abilities. Without denying the pain and frustration of serious problems, SF therapists invite children and adolescents to apply what is right and working in their lives toward solutions. Viewing clients as resourceful opens up solution opportunities that might otherwise remain hidden and unnoticed. Since every person brings a unique blend of resources to the table, customized solutions are developed "one client at a time" based on the person's strengths and successes.

Change is constant and all problems fluctuate. This assumption acknowledges the ongoing flux of human behavior. Regardless of how constant a problem seems, there are always fluctuations in its presence and intensity. Solution-focused therapists are very interested in these "exceptions" to the problem, which are defined as the times in which the problem is absent or less intense. Building on exceptions is a core intervention of solution-focused approaches. The realization that episodes of success and competency co-exist with problems can boost young people's hope in the possibility of solutions—and in their ability to bring them about.

Small changes lead to bigger changes. SF approaches are based on the systemic notion that one small change can ripple into larger and more significant changes. Borrowing from Erickson's idea that therapy is often a matter of "tipping the first domino," SF therapists encourage small goals and small steps toward goals. Every positive action, no matter how small or trivial it may seem, increases the likelihood that other helpful actions will follow.

If it's not broken, don't fix it; If it works, do more of it; if it doesn't work, do something different. These statements capture the pragmatic philosophy of solution-focused practice. While the first statement seems obvious, some therapies delve into areas in which clients are not requesting help. These areas might include deeper meanings or insight, former relationships, or personal growth. Solution-focused therapy addresses specific problems and goals that clients want help with and nothing more. The second statement emphasizes the core theme of SF work, which is to help clients apply their

strengths and resources toward solutions. The third statement urges therapists and clients to hold lightly to theories and techniques and be willing to let them go and try something else when they are not helping to bring about a change.

As evidenced in these assumptions, solution-focused theory emphasizes the processes of change (e.g., collaboration, building on exceptions) over the specific content to be changed (e.g., type or severity of problem). The next section elaborates on SF theory by discussing solution-focused perspectives on psychopathology.

View of Psychopathology

Solution-focused therapists do not adhere to traditional conceptualizations of diagnosis and psychopathology that are based on the medical/disease model—a model that has strongly influenced the helping professions for more than a century (Albee, 2000). In SF approaches, clients are viewed as stuck versus sick and problems are seen as temporary roadblocks versus symptoms of psychopathology. If SF therapists can deliver services and be compensated without assigning a diagnosis, they typically will not assign one. This choice is based on the observation that diagnostic labels can diminish young people's view of themselves and their possibilities, which can happen when the distinction between the label and person becomes blurred.

While the medical model has been a useful framework for assessing and treating physical diseases and ailments, it does not provide adequate direction for treating the social-emotional and behavioral problems that are typically referred to child and adolescent therapists. As a vestige of the medical model and biological psychiatry, psychopathology diagnoses imply that the problem resides within the child or adolescent. In addition to lacking empirical support as a predictive or prescriptive tool (Murphy & Duncan, 2007), categories of psychopathology de-emphasize the impact of situational and environmental factors on the presenting problem. Attaching the problem directly to the child or adolescent can shift people's attention away from more naturalistic, common-sense interventions such as getting more sleep or exercise, altering parenting or teaching practices, eating healthier foods, or modifying the school environment. Diagnostic labels may also reduce people's accountability and persistence when it comes to building solutions. I have seen many young people, parents, and teachers become discouraged and give up in the face of presumably unchangeable "internal disorders" that appear impervious to everyday solutions (e.g., depression, ADHD, bipolar). Even when several professionals reach consensus on what to call a child's problem, the diagnosis itself does not tell the therapist what *this* particular child is doing or not doing that constitutes a problem or, even more importantly, what will help to improve the child's situation.

Despite growing concerns about the validity and usefulness of psychological diagnosis with children and adolescents, many therapists have to assign diagnostic labels for

practical reasons. For example, some children and adolescents have to be diagnosed in order to receive insurance reimbursements and needed services in clinics, schools, and other settings. When SF therapists assign diagnoses, they usually do so in a transparent and collaborative manner, perhaps showing clients a couple of descriptions from the *DSM-5* and asking which ones seem most appropriate: "Do you see yourself as more anxious or depressed? Is there something else that fits your situation better than these descriptions?" In addition to being a more intellectually honest way to assign diagnoses compared to doing so without client input, this approach conveys respect for the client's opinion and reinforces the collaborative nature of solution-focused therapy.

In contrast to approaches that view the diagnoses of psychopathology as a prerequisite of effective treatment, SF practitioners discuss problems only insofar as such discussions validate clients' struggles and point toward solutions. Intake interviews and assessments, like all other client-therapist interactions, impact client perceptions for better or worse (Murphy, 2013). When you think about an intake assessment from the perspective of clients, it is no surprise that clients may feel more discouraged after the assessment than they did before. Solution-focused therapy is based on the commonsense notion that "we get what we're looking for" from clients. When we view clients through the lens of psychopathology, we are encouraging them to do the same. If, on the other hand, therapeutic questions and conversations focus on what is possible and "right" with clients, then they are more likely to experience a sense of hope, empowerment, and possibility that is correlated with better therapeutic outcomes (Alarcón & Frank, 2012; Gassman & Grawe, 2006).

Solution-focused therapists do not deny the pain and reality of serious problems. Nor do they deny the fact that some people may experience a sense of relief from being able to name a problem as the result of a formal diagnosis. That being said, most solution-focused therapists view the language of psychopathology as more of a hindrance than a help when it comes to building therapeutic relationships and solutions with children and adolescents.

THERAPEUTIC GOALS AND INTERVENTIONS

Solution-focused practice is guided by the following therapeutic goals and interventions.

Major Goals

The major goals of solution-focused approaches are to: (a) develop collaborative relationships with clients; (b) formulate concrete goals based on clients' best hopes for therapy; and (c) build solutions from clients' strengths and resources. Solution-focused therapists pursue these goals through a variety of interventions.[1]

Major Interventions

The interventions in this section come primarily from the SFBT treatment manual (Trepper et al., 2012) and from applications of solution-focused practice with children, adolescents, and school problems (Murphy, 2008, 2013). As noted in Chapter 1 of this volume (Prout & Fedewa, 2014), practitioners need to adjust interventions to fit the developmental needs and abilities of each client—which can be particularly challenging with young children and people with significant cognitive or language difficulties. Although a few such adjustments are provided throughout this section, a more thorough discussion of developmental issues and accommodations in solution-focused practice with young people can be found elsewhere (Berg & Steiner, 2003; Murphy, 2013). Key therapeutic ingredients and interventions of SF practice include adopting a collaborative stance, exploring previous solutions and theories, asking solution-focused questions, complimenting clients, building on exceptions, and providing a feedback message. In addition to their usefulness with children and adolescents, these interventions can be used with parents, teachers, and other caregivers.

Adopt a Collaborative Stance

Instead of viewing clients as inferior or defective, SF therapists treat them as capable collaborators who have the wisdom and resources to make important changes. Collaboration is enhanced when therapists "lead from one step behind" (De Jong & Berg, 2013) by trusting that children and adolescents know themselves and their experiences better than anyone else, and by allowing them to teach us what they want from therapy (goals and feedback) and what they already have and do that can help them reach their goals (resources and successes).

Solution-focused practitioners invite clients to participate in every aspect of their care from developing goals to evaluating therapy services. The collaborative aspect of SF practice is based on the practical notion that people are more likely to accept and implement ideas that emerge from their input and resources as compared to uninvited ideas or interventions that are imposed on them by others. As de Shazer et al. (2007) state: "It is always best if change ideas and assignments emanate from the client, at least indirectly during the conversation, rather than from the therapist, because the client is familiar with these behaviors" (p. 5). Whereas other approaches may view clients as "resistant" when they do not implement the therapist's ideas, or do so in ways that differ from the therapist's expectations, SF therapists view these situations as reflecting (a) people's natural tendency to protect themselves by being cautious and taking things slowly, or (b) the therapist's mistake in suggesting an intervention that does not adequately fit the client's circumstances or preferences.

The above strategies increase the likelihood of establishing the type of collaborative relationships that enhance outcomes in child and adolescent therapy (Miller, Wampold, & Varhely, 2008; Shirk & Karver, 2011). Some studies suggest that the establishment of collaborative therapeutic relationships, while important for clients of all ages, are most critical when working with people who experience low levels of social support (Leibert, Smith, & Agaskar, 2011) and young people who enter therapy as involuntary clients with an understandable degree of anger, suspicion, and caution (Bolton-Oetzel & Scherer, 2003; Garner, Godley, & Funk, 2008). When asked what they most need and appreciate from helping professionals, adolescents emphasize the importance of listening to and respecting their ideas and perceptions rather than telling them what to do (Dunne, Thompson, & Leitch, 2000; Everall & Paulson, 2006; Freake, Barley, & Kent, 2007). The fact that most children and adolescents involuntarily enter services at other people's request reinforces the importance of adopting a collaborative stance in working with young clients (McLeod, 2011).

Explore Previous Solutions and Theories

People continually solve problems in their lives, a fact that clients may lose sight of while struggling with a serious problem. For this reason, SF therapists make a point of exploring clients' previous solutions regardless of the type of problems to which they were applied. Possible benefits of asking about previous solutions include (a) boosting hope by reminding clients that they have been successful in resolving other problems, and (b) providing direction for resolving the current problem by avoiding what hasn't worked and applying what has.

The following questions are useful in exploring previous solution attempts:

- How have you handled similar challenges, and how might one or more of those ideas help you now?
- How can your experiences with other problems help you with the current situation?
- What types of things have you (or others) already tried? How did they work?
- Of all the things you have tried, what has worked the best? What would it take to do more of that?

  For clients who have had prior services, therapists can ask:
- What did your counselors do that worked well (and not so well) for you?
- Of all your experiences in counseling, what has helped you the most? How did you turn that into something that was useful to you?
- What was most helpful/least helpful about your previous experiences with helping professionals?

- When you think about people in your life who are (or have been) helpful to you, what is it about them, or what they do, that is most helpful?
- What advice do you have for adults who work with young people?

The following strategies help to clarify clients' theories and perceptions related to the problem and potential solutions:

- Everyone has changed something. How does change usually happen in your life?
- What needs to happen for things to get better?
- If your parents/teachers/friends were here, what would they say if I asked them what needs to happen to make things better?
- Of everything that could be done about this problem, what do you think has the best chance of working?
- Tell me about something you've thought about doing but haven't yet done.

Ask Solution-Focused Questions

> Asking the right question may be the most powerful part of thinking.
>
> —Edward De Bono

Questions are a primary form of communication and intervention in SF therapy (Trepper et al., 2012), which is why they are given extensive attention in this chapter. In discussing the powerful effect of problem-focused and solution-focused questions on clients, Egan (2010) notes:

> Like the rest of us, clients become what they talk about and then go on reinforcing what they have become by talking about it. If you always encourage them to talk about problems, they run the risk of becoming problem people . . . . So be careful about the questions you ask. They should not keep clients mired in problem talk because problem talk can keep clients immersed in frustration, impotence, and even despair. (p. 292)

The remainder of this section describes the most commonly used questions in SF therapy.

Open Questions

Open questions encourage fuller descriptions of clients' ideas and perceptions as compared to closed questions. Instead of asking a lot of closed questions such as, "Do you care about your grades in school?," SF therapists prefer to ask open-ended questions like,

"What are your views on the importance of grades in school?" Other examples of open questions include:

- How will you know that counseling is working?
- What can I do to help you?
- What advice would you give other students who are struggling with this problem?

Relationship Questions

Relationship questions such as, "What would your parents say if I asked what they appreciated most about you?" and "How would you respond to this situation if you were the teacher?" are used in solution-focused therapy to explore (a) the role and perceptions of key people in the child's life, and (b) the social consequences of solutions. The following questions address both of these categories:

- Who are the people you respect the most? What would they do about this problem if they were in your shoes?
- How will your friends/parents/teachers treat you differently when things start getting better? What will that be like for you?
- Of everyone who is involved with this situation, who is most/least concerned about it?

Pre- and Between-Session Change Questions

Based on the fact that many clients report positive changes in the presenting problem prior to attending their first therapy session (Lawson, 1994; Ness & Murphy, 2001; Weiner-Davis, de Shazer, & Gingerich, 1987), solution-focused therapists routinely ask the following "presession change" questions early in the first session:

- Sometimes people notice that things change after they decide to get some help. What have you noticed?
- Has anything changed for the better since you knew that we were going to be meeting?
- What has changed in this situation, if only just a little, after your parents told you that we would be meeting?

Therapists can ask similar "between-session change" questions and strategies in subsequent sessions:

- What's better since we last met?
- When have things been just a little better during the past week?

- Tell me about something good that has happened between you and your parents/teachers/friends since our last meeting.

When clients report positive changes, therapists follow up by exploring (a) the details and conditions under which these changes occurred and (b) what the client or others could do to sustain or increase these changes in the future.

Miracle Questions

Helping clients create practical goals is a central feature of SF therapy. The miracle question was developed by de Shazer (1988) to help clients formulate goals by inviting them to describe life without the problem: "Suppose you were to go home tonight, and while you were asleep, a miracle happened and this problem was solved. How will you know the miracle happened? What will be different?" (p. 5). Variations of the question include the following:

- Suppose a miracle happened tonight and the depression disappears. How would you be able to tell? What would be different? What would your friends/parents/teachers notice that was different?
- If this problem vanished overnight, how would the morning be different for you? How would the afternoon and evening be different?
- Imagine that this school problem completely vanished right here and now. What would you be doing differently, or more of, for the rest of the school day?

Visual images and metaphors can be included in the miracle question to engage young children's attention and help them picture life without the problem:

- If someone waved a magic wand and made this problem disappear, how would you be able to tell things were different at school and home?
- Imagine that we are looking right into a crystal ball at a time in the future when this problem between you and your parents is totally gone. What do you see? What are you and your parents doing differently?
- Pretend there are two movies about your life. Movie #1 is about your life with the problem, and Movie #2 is about your life without the problem. I already know a lot about Movie #1. Tell me what Movie #2 would look like. Who would be in it? What would they be doing?

As illustrated below with Lily, a 12-year-old child referred by her parents for behavior problems at home and school, it is helpful to obtain as much detail as possible about the client's vision of the miracle.

Therapist (T): Suppose a miracle happened while you were sleeping and this problem vanished. What would be different at school?
Lily: I wouldn't get in trouble or have detention after school.
T: What else?
Lily: My grades would be better.
T: What else would be different at school or home?
Lily: My parents wouldn't be talking about school all the time.

Solution-focused therapists encourage small, concrete, action-oriented goals that are stated as the presence of a solution rather than the absence of a problem. They also encourage young clients to focus on self-manageable goals that are under their control and do not require changes in other people's behavior. In following up on Lily's response to the miracle question, the therapist asks several questions to promote these particular features of solution-focused goals.

Therapist (T): You mentioned that you wouldn't get in trouble or have detention. What could you do differently to stay out of trouble and detention? *[This question invites Lily to describe the presence of a solution rather than the absence of a problem.]*
Lily: Pay attention to my teachers and do my work. And get better grades.
T: What would I see if I videotaped you paying attention to your teacher? *[This question encourages a concrete, action-oriented description of the goal.]*
Lily: I'd be looking at the teacher and taking some notes instead of looking at my friends or out the window.
T: Which one of these things would you be willing to work on first, even just a little, during the next couple of days? *[This question keeps Lily in the driver's seat by asking for her opinion on what to work on first. The phrase "even just a little" invites her to focus on small changes instead of large changes that may be overwhelming to her.]*
Lily: I guess "taking notes" because it would help my grades.
T: That makes sense. What is one small thing you can do next week to get a little better on taking notes? *[This question encourages Lily to commit to a small, specific goal.]*
Later in the conversation …
T: You said that you want your parents to stop asking so many questions about school. I wonder what you could do to get them to ask fewer questions about school. *[This statement paves the way for self-manageable goals by inviting Lily to consider what she could do to reduce her parents' questions about school.]*

The miracle question works well with many children and adolescents because they enjoy thinking in playful and metaphorical ways. Another reason it works is because people of all ages appreciate the opportunity to focus on future hopes and possibilities. However, nothing works all the time with every person. When people do not respond to the miracle question or indicate a preference for something different, therapists can honor their wishes and move on to other goal development strategies—such as the one described next.

Scaling Questions

Scaling questions serve several purposes in solution-focused practice, one of which is to help clients formulate goals early in the therapeutic process. As illustrated in the following examples, scaling questions can be framed in various ways to connect with young people and invite them to describe small, specific goals:

- On a scale from 0 to 10, with 10 being the best that things can be and 0 being the worst, where would you rate your overall life right now? What would the next higher number look like?
- If a score of 10 is where you want things to be when we finish counseling and 1 is where things are now, what will be different when it moves up to 2? How will you and others be able to tell that you moved up?
- Show a young child five wooden blocks and say, "I want to know how things are going in school right now." While arranging five blocks in a row or tower on the table, say, "This [pointing to the stack or row of five blocks] means things are really great, just the way you want them to be at school, and this [pointing to one block] means things are really bad at school. Use those blocks to show me how things are going for you at school right now. [After the child responds] Okay, what can you do at school this week to give yourself another block?" Therapists can use pencils, paper clips, or other available objects for the same purpose.

In addition to helping clients develop goals, scaling questions provide a snapshot of progress and outcomes from the client's perspective. Many SF therapists begin each session by asking, "On a scale of 1 to 10, with 1 being 'the worst it can be' and 10 'the best it can be,' how would you rate your situation during the past week?" Relationship questions can be framed in a similar scaling format to get a sense of other people's perceptions: "Where would your teachers/parents rate the situation?" It is important to invite clients to elaborate on their ratings through follow-up comments and questions:

- What is different about this week that you rated a "4" and last week that you rated a "6"?

- Wow, that's four points higher than last week! What did you do to make that happen?

Scaling strategies can also be used to obtain client feedback on the overall usefulness of services or of a particular therapy session: "On a scale from 0 to 10, how useful was today's meeting?" Given the growing body of empirical research supporting the use of formal client feedback measures in therapy (Duncan, 2014; Lambert & Shimokawa, 2011), some authors have described how brief client feedback surveys can be integrated into the solution-focused therapy process (Gillaspy & Murphy, 2012; Murphy, 2013).

Exception-Related Questions

The search for "exceptions"—times in which the problem is absent or less noticeable—is a foundational technique of solution-focused therapy. Exceptions can be viewed as solutions that are already happening, though not as intensely or often as desired. The strain of a serious problem makes it hard for people to notice small but important fluctuations in the problem's intensity or frequency. De Shazer (1991) observed that "times when the complaint is absent are dismissed as trivial by the client or even remain completely unseen, hidden from the client's view" (p. 58). These potential building blocks of change may go unnoticed unless therapists ask for them through the following types of questions for children, adolescents, and caregivers:

- When is the problem absent or less noticeable?
- Which class at school do you get in the least amount of trouble?
- When have things been just a little better during the past week?
- When do you and your daughter get along best?
- [As follow up to a scaling question] Tell me about a time during the past month when things were a little higher than a 3.
- [As follow up to the miracle question] What part of the miracle is already happening, if only just a little?

Exception-finding questions can be folded into conversations about the presenting problem and therapeutic goals. When discussing when and where the problem typically occurs, we can ask about the times and places in which the problem is least noticeable. As illustrated in the questions listed above, miracle and scaling questions also provide opportunities to discover exceptions. When clients say, "I'd smile more and feel more relaxed" when asked to describe the next highest number on their scale, therapists can ask about a recent day or situation in which they smiled more often or felt more relaxed. After clients describe life without the problem in response to the miracle question, therapists can discover exceptions by asking, "What small pieces of the miracle are already happening, even just a little?"

Once an exception is discovered, therapists can clarify related details and circumstances. For example, an adolescent who misbehaves in every class except history can be asked:

- What is different about your history class/teacher from your other classes/teachers?
- How do you manage to behave so well in history class?
- What is different about your approach to history class compared to your other classes?

Similar questions can be used with teachers and parents to clarify exception-related details and circumstances:

- What was different about last Tuesday when Jeremy behaved better in your class? What did you do or say differently?
- Does Jeremy behave better on certain days of the week or during certain activities in your class?
- What is different about the times when you and your daughter get along better?

Exception-related questions reveal what clients are already doing to make their lives better, which provides the foundation for exception-building interventions that encourage them to do more of what is working. Strategies for building on exceptions are discussed later in the chapter.

Coping Questions

While being careful not to minimize the pain and distress of a serious problem, SF therapists assume that all clients are doing something—often several things—to help themselves cope with the problem and keep it from getting worse. The following coping questions are used (a) to follow up on times when clients report that the problem has not changed, and (b) to discover and build on the client's overall coping skills and resources.

- When you think of other tough times in your life, what has helped you get through? How might one or more of those things help you with the current problem?
- How have you kept things from getting worse?
- This is a very tough problem. How have you managed to cope with it so far?
- Where do you find the strength to keep trying?
- How did you resist the urge to react the way you usually do when someone calls you a bad name?

Coping questions remind clients that even in the face of serious struggles and failures, they are doing something to help themselves and to keep things from getting worse.

Compliment Clients

Complimenting is an essential part of SF therapy that invites young people to adopt a more hopeful view of themselves and their situation. Some children have received very few compliments in their lives, which makes it hard for them to muster up the hope and energy required to tackle difficult problems and persist in their efforts to resolve them. Many clients enter therapy fatigued and demoralized as a result of wrestling with a problem for weeks or even months. Anything we can do to boost the client's hope will improve outcomes (Alarcón & Frank, 2012), which is why SF therapists frequently compliment clients on their positive attributes and actions. Here are a few examples:

- Everyone has tough times, but not everyone has the strength to do what you're doing by coming here and meeting with me to try to make things better.
- I'll bet it was really hard to learn skateboarding. How did you do that?
- [Following the client's report of a successful idea or action] Where did you find the courage to do that?
- Since you've become somewhat of an expert at turning things around at school, would you be willing to help others by sharing your ideas and wisdom?
- With all you've been through, what has prevented you from giving up altogether?

In a study of the relationship between outcomes and different aspects of solution-focused therapy, the practitioner's use of compliments correlated strongly with positive client outcomes (Linssen & Kerzbeck, 2002). Compliments serve to validate what young people are already doing well and to acknowledge their struggle.

In discussing the benefits of positive approaches with children and youth, Wolin, Desetta, and Hefner (2000) encourage therapists to "look for strengths in even the most troubled young people and encourage them to search for examples of their own competence" (p. 4). In my own practice, I have found that certain compliments are applicable to most young clients and their caregivers. For example, people can be complimented for: (a) attending the therapy session ("It takes courage to meet like this"); (b) cooperating with the therapist and the therapy process ("I know I'm asking you a lot of questions and I really appreciate your patience in answering them"); and (c) trying to improve their lives or those of their children/students ("It takes a lot of caring and courage to keep trying instead of giving up when things don't work the way you want them to").

Build on Exceptions

Building on exceptions to the problem is a core intervention in solution-focused practice. As discussed earlier, questions such as "When is the problem less noticeable at school?" and "What is different about those times?" help to identify and clarify exceptions. Once therapists discover and explore exceptions, they encourage clients

to replicate the exceptions in other situations. This is referred to as "gently nudging" clients to do more of what is already working, sometimes in the form of an experiment (de Shazer et al., 2007). A short example of building on exceptions is provided below.

In working with Julian, an adolescent referred for disruptive behavior at school, the therapist discovered that Julian received notably fewer discipline referrals from his science teacher compared to his other teachers. When asked what was different about science class and his approach to it, Julian said "the teacher is pretty cool" and the class is "more interesting" than his other classes. The therapist asked for more details and discovered that Julian took more notes in science class, sat toward the front of the classroom, did more homework, and arrived to class on time. The therapist and Julian discussed an "experiment" in which he might (a) implement one or more of the exception behaviors in one of his other classes during the coming week, and (b) observe any differences that result from his experiment.

Provide a Feedback Message

Many solution-focused therapists take a 5- to 10-minute break toward the end of each session in order to collect their thoughts and construct a feedback message for clients. The message typically consists of three components—a compliment, a bridge, and a suggestion (De Jong & Berg, 2013).

The end-of-session compliment is intended to validate what is important to clients and affirm their strengths and successes. Here is an example from a session involving Marisa, a 17-year-old adolescent referred by her parents for ongoing defiance and running away from home: "Marisa, it is clear to me that you are a courageous person who doesn't give up when things get tough. Meeting with me today is another example of your courage and willingness to hang in there and keep trying to improve things between you and your parents." Many clients are relieved and surprised to receive such compliments because they may be expecting to hear bad news about themselves or their situation. In addition to boosting hope, compliments remind children and adolescents that they possess important solution-building assets.

The bridge connects a send-off suggestion by providing a rationale for the suggestion. The rationale is based on the client's goals, perceptions, and strengths. For example: "I agree with you, Marisa, that it will be very difficult for you to continue living at home unless things change between you and your parents. That's why I want to offer a suggestion for you to consider."

Having provided compliments and a bridge, SF therapists offer an observational and/or behavioral suggestion based on the clients' goals, exceptions, preferences, and motivations. Observational suggestions invite people to carefully observe specific aspects of their lives that may be helpful in constructing solutions: "Pay attention to the times when you get along a little better with your parents, and make note of what's

different about your approach to them or their approach to you. You could even make a list of these differences and bring it to our next meeting." Behavioral suggestions invite clients to take action, often in the form of an experiment. "If you're willing to try an experiment, I wonder what would happen if you thanked one or both of your parents for one thing every other day this week, and carefully observe any differences in your relationship with them."

As illustrated with Marisa, the feedback message provides the opportunity to end therapy sessions on a positive note by inviting clients to acknowledge and apply their resources in solution-building ways. Up to this point, the chapter has focused on the application of solution-focused ideas and techniques to individual therapy with children and adolescents. The next section describes how these ideas and methods can be applied to other contexts and services involving children and adolescents.

GROUP WORK WITH CHILDREN AND ADOLESCENTS

The ideas and methods of solution-focused approaches lend themselves very well to group applications (Corey, 2012; Metcalf, 1998; Sharry, 2007) and have been successfully applied to a variety of child and adolescent groups including the following: Adolescents who experience serious problems with substance abuse (Froeschle, Smith, & Ricard, 2007), test anxiety (Murphy, 2008), and school behavior (Conoley et al., 2003; Corcoran, 2012; Franklin, Moore, & Hopson, 2008; Murphy, 1994); adolescents with developmental disabilities (Murphy & Davis, 2005); children who struggle with obesity (Rudolf et al., 2006); and Hispanic children of incarcerated parents (Springer, Lynch, & Rubin, 2000), to name just a few.

The collaborative, client-driven aspect of solution-focused practice is helpful in encouraging groups of young people to take more responsibility for developing solutions based on their successes, strengths, and wisdom. Group leaders can orient members toward strengths and resources by asking about aspects of their lives that are working well and exploring how they can apply these assets to their goals. Formal or informal scaling strategies can be used at the beginning and end of each meeting to assess members' perceptions of progress and to obtain their feedback on the usefulness of the meeting. As with individual therapy, a strong alliance between the group leaders and members will improve the outcomes of any group.

Most young people are selected to participate in a group as a result of specific problems, and it is helpful to hear about and validate their struggles and frustrations with the problem. In transitioning from problem-based to solution-based discussions, the group leader might say something like this: "I appreciate you telling me about the struggles that brought you here because it helps me understand where you've been and what you've gone through. It's also important for me to know about the times when your problems

don't happen or when they're less noticeable, even if it's just for a few minutes. If we can figure out how those times are different from the problem times, then it might give us some ideas about how to make things better. Does that make sense?" The remainder of this section describes solution-focused elements of a group that I led for adolescents who experienced significant test anxiety (Murphy, 2008).

Example: Adolescent Test Anxiety Group

The group consisted of five female adolescents, ages 15 through 17, who signed up for an after-school group addressing test anxiety. They participated in 6 weekly, 1-hour meetings. Solution-focused strategies were used in conjunction with educational and skill-building activities such as study strategies, test-taking tips, and relaxation exercises. During the first meeting, students completed a few basic information forms and shared what they wanted from the group and how they would know if the group was successful for them. Most of their goals centered around better study habits, improved test performance, and less worry and anxiety before and during important tests.

The following questions were asked at the start of the second meeting to explore exceptions related to the group's goals.

- Tell me about a test within the last month or so that you did a little better on. What was the subject area of the test? What was different about this test compared to other tests? What was different about the way you prepared for it? What did you do differently right before the test? What did you do differently during the test?
- Think of a recent test that you studied for more effectively than usual. How did you study for this test? How was that different from the way you usually study?
- Think about a recent test that you worried a little less about. How did you manage to do that? What does that tell you about yourself?

These questions yielded numerous exceptions, the details of which were explored during the remainder of the meeting. The group appreciated the opportunity to discuss what they were already doing that was "right." One person commented, "I thought I was doing *everything* wrong." I also asked what they thought about doing but had not yet tried. At the end of the second session, members were given the following variation of the formula first session task in SF therapy: "Between now and next week's meeting, observe and make a list of all the things that you are doing to prepare for and take tests that you want to continue doing."

As is often the case when people are asked to consult on their own problems, the strategies reported by the group members were very similar to established interventions in the test anxiety literature with one important difference: Every idea was indigenous

to this particular group in this particular place at this particular time, uniquely worded and styled in the language of its members. In subsequent meetings, educational materials on test-taking, relaxation, and study skills were integrated with member-generated language and ideas to enhance the relevance and acceptability of group discussions and intervention strategies. The last three meetings opened with a question that is commonly used at the beginning of solution-focused groups: "What's better since our last meeting?" Members liked this question and the meetings got off to a positive, solution-focused start.

Changes in group members' test performance and academic grades indicated that the group was successful. Four of the five adolescents increased their overall grade point average in school, and all five reported improvements in test-taking skills on a self-report survey.

SCHOOL AND PARENT APPLICATIONS

This section describes several ways in which solution-focused principles and practices can be applied in several educational and parental contexts.

Classroom Management and Teaching

Several authors have described how solution-focused ideas can be incorporated into classroom management and teaching (Berg & Shilts, 2005; Metcalf, 1999; Murphy, 2008). Various components of solution-focused practice are consistent with research on effective teaching. For example, several researchers (Baker, Grant, & Morlock, 2008; Pianta & Stuhlman, 2004) have reported links between children's academic and social success and teachers who do the following:

- Respect the integrity and individuality of students.
- Demonstrate confidence in their ability to act responsibly and productively.
- Encourage them to examine and resolve their own problems.
- Involve them in classroom decisions.
- Facilitate positive teacher-student relationships.

Just as solution-focused therapy emphasizes the importance of client-therapist relationships, a solution-focused approach to classroom management and teaching rests largely on strong student-teacher relationships that encourage students' active involvement in learning and decision-making (Baker et al., 2008). Effective teachers manage the process and structure of the classroom while encouraging student involvement by (a) providing opportunities for them to experience success and to share their opinions, and (b) connecting instructional topics and activities to the life experiences and interests of students (Doll, Zucker, & Brehm, 2004). For example, in presenting a geography

lesson, the teacher might encourage students to read or write about a place they have visited or have a special interest in.

A solution-focused approach to teaching can also help prevent and resolve classroom behavior problems (Kelly, Liscio, Bluestone-Miller, & Shilts, 2012). Effective teachers recognize and build on their students' strengths, resources, and successes instead of attending only to their mistakes and problems (Goldstein & Brooks, 2007). For example, the teacher could ask a child who displays behavior problems to present a class report or write a paper on a personal hobby or strength. This strategy might help to improve the teacher–student relationship as well as highlighting the student's unique talents and resources. The teacher could also request the child's opinion of what might help turn things around for the better at school. As illustrated in this chapter, helping professionals have nothing to lose and much to gain by enlisting clients as consultants on their own problems and goals.

Whether in the role of therapy clients or students, young people greatly appreciate the opportunity to have a voice in their own care and education. Even when they have no specific ideas for improving things, inviting their input conveys respect and can enhance student-teacher relationships.

Berg and Shilts (2005) developed the WOWW (Working on What Works) program, a solution-focused approach to teaching and classroom management for implementation in K-12 classrooms. This program seeks to improve teacher–student relationships by empowering teachers to recognize and apply their strengths as well as their students' strengths in setting goals and working in a collaborative manner. The WOWW program derives from solution-focused attitudes and assumptions about teachers, students, and parents that include:

- Teachers want to have positive relationships with all children and provide them with learning environments and opportunities that will help them be successful in school and elsewhere.
- Students want to please their teachers and parents, learn new things, have input in their learning, belong to a group, and be accepted by other children and adults.
- Parents want to have a positive influence on their children and want their children to learn and succeed in school and in life.

The WOWW program incorporates many techniques of solution-focused therapy approaches including compliments, exceptions, goal-setting, scaling, and coping questions. Teachers make ongoing efforts to involve students in learning and classroom decision-making by requesting their input in regularly scheduled class-wide meetings as well as individual meetings with students. The program also includes a coaching element in which mental health professionals who are highly familiar with solution-focused

ideas provide consultation and technical assistance to teachers who implement the program in their classrooms. In keeping with the cooperative nature of solution-focused practice, developers of the WOWW program recommend using it only with teachers who voluntarily participate. Preliminary studies suggest that the WOWW program can be useful in: (a) increasing teachers' perceptions of their students as better behaved; (b) increasing teachers' perceptions of their effectiveness as classroom managers; and (c) reducing absenteeism, tardiness, detentions, and suspensions.

Parenting

Many of the solution-focused techniques that have been effectively applied by classroom teachers have been recommended for use by parents (Harris & Franklin, 2012; Metcalf, 1997; Selekman, 1993). Instead of describing all of these techniques as they apply to parenting, I briefly describe two solution-focused parenting programs.

Selekman (1993) describes a solution-focused group for parents of adolescents involving 6 modules addressing the following areas and strategies: (a) paying attention to what is going well at home with their sons and daughters and in their relationship with them; (b) setting specific parenting goals and taking small steps toward their goals; (c) observing what works best and doing more of it; (d) observing what does not work and doing something different; and (e) celebrating any signs of progress and sharing success stories with the group.

In their work with adolescent parents in a group program called Taking Charge (TC), Harris and Franklin (2012) emphasize the importance of helping parents set specific, action-oriented goals and build on their own strengths and resources in their efforts to help their children. Given the challenges of parenting—especially young parents who can become easily discouraged—the TC program involves a healthy dose of compliments throughout the intervention process. Empirical studies of the TC program have indicated that it increases the likelihood of adolescent participants staying in school and using effective coping skills and behaviors.

Teacher and Parent Consultation

As key caregivers in the lives of young people, parents and teachers are often involved in the treatment of child and adolescent difficulties. Many aspects of solution-focused practice can be effectively applied to teacher and parent consultation regardless of one's theoretical orientation. Practitioners can validate teachers' or parents' struggles, explore their ideas, acknowledge their resilience, involve them in important ways, and request their feedback throughout the duration of services. Teachers, parents, and other adults respond well to respect, validation, collaboration, and other key elements of solution-focused practice as described in this chapter.

Many practitioners who work with children and adolescents find it easier to apply solution-focused ideas with children and adolescents compared to their caregivers. For example, instead of validating and going with the flow as a teacher or parent describes the situation, the practitioner may have difficulty being patient and resisting the urge to tell the teacher or parent what to do. Whatever the reason, it is equally important to work with young clients *and* their caregivers in solution-focused ways in order to maximize the benefits of services. More specifically, outcomes are enhanced when providers (a) work on goals that are important to parents and teachers, (b) collaborate with them in developing interventions instead of trying to coerce them into implementing interventions, and (c) provide ongoing opportunities for them to stay involved and provide feedback on the usefulness of services. In summary, much of what works in solution-focused therapy with children and adolescents works in consulting with their teachers and parents.

Parent-School Conferences and Relationships

School problems are common among children and adolescents who receive psychotherapy services. As a result, their parents are often involved in meetings with teachers, administrators, counselors, and school psychologists. Parent-school relationships have received considerable attention in recent years, due in part to a growing body of research linking students' school success to parent involvement (Christenson & Carlson, 2005). Parent conferences have been an integral part of school life for many years, and for good reason. As the primary caregivers in the student's life, parents and guardians often hold a wealth of information and influence that is very useful in addressing school problems. School personnel can enhance the quality of parent-school conferences by approaching parents in solution-focused ways.

Parents of children with school problems typically are contacted by the school *only* when their child is in trouble. This may lead parents to avoid schools as much as possible because most or all of their interactions with school personnel are negative. The solution-focused practice of recognizing small successes urges school personnel to occasionally contact parents when their child has a better day or week at school. Imagine your reaction, as the parent of a struggling student, if you were called by a teacher or school counselor to inform you that your child had a good day at school. You might even be asked for your theory on how the improvements occurred and what you did to help bring them about.

Approaching parent conferences in solution-focused ways encourages school personnel to interact with parents in respectful ways (Carlson, Hickman, & Burrows-Horton, 1992). In meeting with parents, school personnel can begin the conference on a collaborative note by acknowledging the unique expertise and experience that parents bring to the table: "You know your child better than anyone else, and we really need

your help here." Opening parent-school conferences in this manner lets parents know that their ideas and experiences are respected and valued by school personnel. The solution-focused approach can be extended even further by asking parents about exceptions ("Pay attention to the times that Chelsea minds you better at home" or "Tell us about some things that you want to continue happening with Chelsea at home and school") and other child and parent resources ("What have you found works best in helping Chelsea behave productively at home?" or "Who has the most influence with Chelsea?"). These are just a few examples of how solution-focused ideas can be used to improve the quality of parent-school conferences and relationships. See Carlson et al. (1992) for additional ideas on approaching parent-school conferences in solution-focused ways.

EFFECTIVENESS RESEARCH

Research has played important roles in the origins and development of solution-focused therapies. Guided by the practical question, "What works in therapy?," the original members of the BFTC in Milwaukee "utilized a research approach that relied on clinical observations and client data to discover which therapeutic techniques would most effectively facilitate behavioral change" (Lipchik et al., 2012, p. 3). Unlike formal outcome research and efficacy studies that involve hypothesis-testing, tight controls, randomized designs, and quantitative analyses, early research at the BFTC was more exploratory, qualitative, and practice-based—an approach that was well-matched to the beginning stages of model building and the discovery of new therapeutic techniques at the BFTC (Lipchik et al., 2012). Instead of starting out with directional hypotheses about what worked or did not work in therapy, the original Milwaukee group diligently observed and documented therapeutic ideas and methods that led to positive changes for clients.

Although no controlled efficacy studies were conducted at the BFTC, the effectiveness of solution-focused therapy and some of its specific methods was investigated using client surveys and self-reports. In one study, de Shazer et al. (1986) reported a 72% success rate for solution-focused therapy based on a survey in which clients were asked to indicate whether or not they had met their goals for therapy. In a similar study, 82% of clients surveyed at 6 to 18 months follow-up indicated that therapy was successful for them (de Shazer, 1985). In examining the effectiveness of the formula first session task, in which clients are asked to observe the things in their lives that they want to continue happening, 50 out of 56 new clients (89%) reported that something desirable had happened. Forty-six (82%) of them reported that at one or more of the events that they wanted to have happen in their lives was "new or different" (de Shazer, 1985, p. 155). In a

study of the presession change intervention described earlier, 20 of the 30 new clients (66%) who were surveyed reported that they noticed desirable changes in the presenting problem prior to their first therapy session (Weiner-Davis et al., 1987).

The number and type of published studies on solution-focused therapy have grown steadily over the past two decades. Most studies have examined solution-focused brief therapy (SFBT), which is clearly the most popular and well-researched form of solution-focused practice. The depth and scope of SFBT studies have improved and expanded over time to include randomized designs, treatment integrity checks, and a variety of outcome measures in addition to client self-report. Gingerich, Kim, Stams, and MacDonald (2012) recently reported a total of 48 published studies and two meta-analytic reviews. The effectiveness of SFBT research has been put to the empirical test with an increasingly broad range of client populations, contexts, and challenges including families, couples, children, adolescents, child abuse, foster care, and school problems (Franklin et al., 2012).

When taken as a whole, research studies have shown that SFBT works about as well as other approaches but does so in fewer sessions and, therefore, at lower costs (Gingerich, Kim, Stams, & MacDonald, 2012). In meta-analyses conducted over the past decade, SFBT showed modest effect sizes and outcomes that were generally equivalent to other approaches (Gingerich et al., 2012). Empirical studies of SFBT generally have addressed overall client outcomes, but some have examined the impact of specific processes and techniques of SFBT. McKeel (2012) has reviewed and summarized the results of many such studies, which include:

- SFBT techniques have been shown to enhance the hopes and expectations of child and adult clients in regard to reaching therapeutic goals and improving their lives (Corcoran & Ivery, 2004).
- In a study where 52 clients were randomly assigned to SFBT or problem-focused therapy, SFBT clients reported relatively higher expectations that they would reach their therapeutic goals than clients who received problem-focused therapy (Bozeman, 1999).
- McKeel (2012) reported that the miracle question, formula first session task, and scaling questions were correlates of effective change and that SFBT generally instills hope and optimism in clients.
- Simon and Nelson (2004) obtained the following results after asking 91 SFBT clients what they found to be most helpful about their therapist: 56 clients (58%) said the therapist's approach (e.g., assigning homework, asking questions, and other techniques) was the most helpful factor, and 12 clients (14%) reported that the therapist's encouragement and feedback was the most helpful aspect.

- Clients who have received SFBT report benefits and appreciation of SFBT's positive focus on client strengths and successes (Mireas & Inch, 2009) and validation (Lee, 1997).
- In a study of SFBT with families who have a child with severe intellectual disabilities, the parents—who rarely hear any good news from helping professionals—expressed appreciation for, and empowerment from, the therapist's acknowledgement of their skills and successes with their children (Lloyd & Dallos, 2008).

The majority of research on solution-focused therapy has involved adult clients. Of the studies that have specifically targeted child and adolescent clients, most have been conducted in schools. In addition to providing ongoing access to children and teens, the school setting is an excellent context for solution-focused approaches for the following reasons: (a) solution-focused therapy has been effectively used with various involuntary and mandated client populations (Clark, 1998; De Jong & Berg, 2013; Lee et al., 2012), a description that fits many students who enter school-based intervention services against their will at the behest of caregivers such as teachers or parents; (b) most schools lack the time and money required for long-term therapeutic interventions; (c) the collaborative nature of SFBT fits well with the school culture of teaming and collaboration as evidenced in Response to Intervention (RTI) programs and Individual Education Plan (IEP) teams; and (d) the positive, strength-based emphasis of solution-focused practice is well-suited to the recent emergence of school-wide positive behavior support (PBS) programs (Storey & Post, 2012). These reasons may explain the growing number of publications that advocate and describe the implementation and success of solution-focused interventions with children, adolescents, and school problems (Bertolino, 2003; Kelly, Kim, & Franklin, 2008; Murphy, 2008, 2013; Selekman, 2009).

As is the case with many therapeutic approaches for children and adolescents, the implementation of solution-focused interventions in schools far exceeds the amount of empirical research that has been conducted in school settings. So far, SFBT has been empirically shown to improve a wide range of school problems experienced by children and adolescents including poor academic performance (Franklin, Streeter, Kim, & Tripodi, 2007; Newsome, 2004), erratic school attendance (Franklin et al., 2007), classroom disruption, and various other behavioral problems (Franklin, Biever, Moore, Clemons, & Scamardo, 2001; Franklin, Moore, & Hopson, 2008; Froeschle et al., 2007; Murphy, 1994). In a comprehensive review of empirical studies of SFBT, Kim (2008) reported that the outcomes studies conducted in schools have generally yielded medium effect sizes.

Continued research on the application of solution-focused therapy with children and adolescents is sorely needed. While research findings suggest that solution-focused approaches show solid promise with young clients, the increased quality and quantity of

future research on solution-focused therapy will sharpen and expand the evidence base on this promising, practical approach to counseling and psychotherapy with children and adolescents.

CONCLUSION

A quick story, adapted from Shah (1983), captures the difference between solution-focused and traditional, problem-focused approaches. Maurice was walking along the neighborhood one evening when he saw his friend Tom crawling around on his hands and knees looking for something under the streetlamp. When Tom explained that he had lost his keys, Maurice joined him in the hunt. After a few minutes of searching with no success, Maurice asked Tom where he was when he dropped the keys. "Over there," Tom said while pointing to a parking lot across the street. Puzzled by his friend's response, Maurice asked the obvious question: "If you dropped your keys all the way over there, then why are you looking for them here?" "Because the light is so much better here," Tom replied as he resumed his search.

Many traditional approaches to child and adolescent therapy follow Tom's lead by searching for solutions under the familiar light of diagnosis and symptom reduction despite a growing body of research suggesting that therapeutic solutions are more likely to emerge from client strengths, resources, and collaboration. These are the very elements that comprise solution-focused therapy with young people and their caregivers.

Case Study

This illustration involves an adolescent (Maria, age 13) and her parents (Rosa and Manny). During the first meeting with Maria and her parents, Rosa explained that she and Manny decided to seek professional assistance because Maria's "emotional outbursts" were becoming more frequent and intense. They felt like they were fighting "constantly" and were very concerned about Maria's increasingly unpredictable and explosive responses to "anything that doesn't go her way." Manny was particularly worried about the long-term consequences of Maria's inability to control her emotions, fearing that these tirades would hurt her chances in life and that she would be doomed if she kept responding so strongly to life's inevitable ups and downs. Both parents were very concerned about their eroding relationship with their only child.

The therapist helped Maria and her parents formulate goals by asking, "How will you know if our meetings are working two months from now?," and the scaling questions, "On a scale of 1 to 10, where 1 is the worst it can be and 10 is where you want it to be, where would you rate your relationship with your daughter/parents?" and "What will be happening differently when this number goes up one point?" Although the parents and Maria described their goals in different ways, everyone agreed that "speaking to one

another in calm voices" and "finishing their conversations" would represent positive steps toward a better future. The therapist delivered the following feedback messages separately to Maria and her parents at the end of the first session:

- Maria, I appreciate your courage in coming here and talking with me today because it is not an easy thing to do (compliment). I also appreciate you being honest and telling me that you were not sure what would improve things at home, which is why I wanted to toss out an idea for your consideration (bridge). I want you to make a list of everything about you and your parents that you want to continue happening, and we can discuss the list at your next meeting. How does that sound?
- Rosa and Manny, I can see that you love your daughter deeply and want the best for her. The very fact that you took this step speaks volumes about your commitment to Maria, and she is lucky to have you in her corner (compliment). I know the last few weeks have been especially difficult and frustrating, which is why I want to leave you with a couple suggestions (bridge). First, make a list of everything about Maria and your relationship with her that you want to continue happening. Also, pay attention to the times when you get along a little better with Maria, and make a quick note of anything that is different about those situations. How does that sound?

All of these suggestions invited the family to search for exceptions to the seemingly "constant fighting" and Maria's "uncontrollable emotional outbursts." Maria and her parents made a quick note of these suggestions and agreed to carry them out over the next week. Rosa commented that she liked the suggestions because things had become so negative that they were all walking on eggshells at home. When Manny asked if they should tell Maria what they were observing, the therapist left it up to them to decide. When asked when they wanted to meet next, they decided that 2 weeks would give them ample time to carry out the suggestions.

When they returned a couple weeks later, Rosa, Manny, and Maria each reported higher numbers on the scaling questions. They said that they had recently sat down after dinner to review their observations with each other. Despite the seeming constancy of the problems, everyone shared a list of nonproblem events (exceptions) and positive attributes about each other. Maria was observed on numerous occasions being more communicative, more cooperative, and better able to keep her emotions in check. Maria also noted several positive attributes about her parents, not the least of which was that they genuinely cared about her and wanted her to be happy. As is often the case in response to exception-finding observation tasks, everyone was pleasantly surprised that their list

was as long as it was because it felt like they were fighting constantly and nothing was going right in their relationship.

The therapist explored the details of the exceptions reported by Maria and her parents by asking what each of them had done to bring about the exceptions and make things better at home. For example, when discussing Maria's emotional outbursts and what each person did to improve the situation, Manny commented that his "backing off" and "appreciating Maria's strengths" seemed to improve things around the house and in his relationship with Maria. Maria observed that she got what she wanted a lot more when she had a friendly attitude and made attempts to talk with her parents about everyday stuff rather than only confronting them when she was mad. Rosa observed that when a disagreement occurred, all three of them were getting better at taking it in stride rather than blowing it up to a huge problem. In short, everyone seemed to be trying just a little bit harder to get along. The second session concluded with compliments and the joint suggestion to continue observing the good times and making note of what everyone is doing to contribute to them.

The third and final session occurred 2 weeks later. Maria and her parents reported that things kept getting "much better and calmer" at home. As in the previous session, the therapist asked for specific details about the changes and about each person's contributions. In addition to helping the therapist learn what each person was doing to make things better at home, inviting them to articulate their specific contributions was intended to help them sustain and increase their successful efforts and behaviors.

In order to further amplify and empower the recent changes, the therapist asked them to describe their home life before and after things improved. Rosa and Maria reported "more harmony" and "a calmer atmosphere." Manny became emotional when he described his "before and after" experiences with Maria, stating that he never realized how deeply important his relationship with his daughter was until they started having these problems. He also did not realize how many things he admired and respected about Maria, which included the fact that she was not swept away by the urge to wear the right clothes, have the right friends, or do other such things in order to be popular at all costs "like so many other girls her age." Manny continued as Maria and Rosa looked on with tears in their eyes. "I'm proud that Maria is more interested in what is happening in the world and what people could do to make it better." Finally, he said that he and Maria scheduled a political night to discuss politics and world events, which strengthened their relationship in ways that neither could have predicted.

When asked where they wanted to go from there, the family elected to discontinue therapy. The therapist thanked Maria, Rosa, and Manny for their cooperation, complimented them on their hard work and commitment, and wished them well.

NOTE

1. Solution-focused therapists generally prefer the word *idea* to intervention because it fits better with the collaborative notion of working "with" clients rather than doing something "to" them. However, the term *interventions* is used in this chapter for the sake of consistency.

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Written primarily for practitioners and scholars, this volume includes contributions by an international set of experts on SFBT theory, practice, and research. Chapters cover a wide range of problems, settings, and clients including domestic violence offenders, runaway youth, K-12 students, child protection clients, adults with substance abuse problems, and people with schizophrenia.

Murphy, J. J. (2008). *Solution-focused counseling in schools* (2nd ed.). Alexandria, VA: American Counseling Association.

This volume, named Book of the Year by the American School Counselor Association, translates the ideas of solution-focused therapy into practical, research-supported techniques designed for school-based counseling with students, parents, and teachers. Counseling strategies are illustrated through dozens of examples and dialogue from real-world counseling sessions involving preschool through secondary students and their caregivers. The book's appendices offer practical forms and materials for everyday use in providing counseling and other school-based mental health services.

Murphy, J. J. (2013). *Conducting student-driven interviews: Practical strategies for increasing student involvement and addressing behavior problems*. New York, NY: Routledge.

This book (a) provides solution-focused strategies for increasing students' involvement in every aspect of their care from goal development through evaluation of services and (b) offers step-by-step guidelines and illustrations for approaching every conversation as an opportunity for change. It also includes a companion website with interview protocols, sample referral forms, and tips for teachers and parents.

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CHAPTER

9

Systemic Approaches

Family Therapy

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The systemic theories of psychotherapy are unique in considering the dynamic relationship between symptomology and the interpersonal context in which these symptoms occur. Systems theorists believe that the system (e.g., a family) is made up of complex relationship patterns between its members and between its members and the outside world. These patterns lead to clinically relevant symptoms. For example, Family A has a 7-year-old daughter who is depressed and withdrawn. In addition to considering the unique characteristics of the girl, a family therapist would view the family itself as a unit of focus. In the same way, symptoms of depression and withdrawal in various family members are viewed as being maintained by the structure, patterns, and beliefs of the family. In turn, the depression and withdrawal permit the family to operate with the least amount of change and the most amount of predictability. Systemic thinking represents a dramatic epistemological shift from other approaches to psychotherapy, particularly with the premise that etiology and history are less relevant than an understanding of current family structure, interaction patterns, and belief systems. Following early development of these theories and interventions another wave of narrative and solution-oriented approaches were described and embraced, particularly for families and therapists who were only focused on the problems and not on the positive aspects of families. More recently, these theories have expanded further to include being able to increase the depth and breadth of thinking and possible interventions. Systemic thinking and family therapy have contributed greatly to the ways in which children, adolescents, and families can receive assistance.

Our overview theory described in this chapter is a systemically grounded approach to treating children, adolescents, and their families. It integrates general systems theory with the major schools of family therapy that have evolved over the last 40 years, each focusing on a different aspect of family dynamics or an approach to treatment. Family therapy is much more than an additional technique in the mental health practitioner's bag of tricks. Family therapy represents a worldview that encompasses the entire treatment process: conceptualizing, assessing, and intervening.

HISTORICAL PERSPECTIVE

The decade following World War II was formative for the family therapy movement. Goldenberg and Goldenberg (1985) point to five seemingly independent scientific and clinical developments that together set the stage for the emergence of family therapy (p. 90). The first one was the adaptation of psychoanalytic formulations to the study of the family. Nathan Ackerman, a psychoanalyst and child psychiatrist, is credited with extending this orientation beyond the inner life of individuals to the individuals within their family, community, and social contexts. Second, general systems theory, proposed by Ludwig von Bertalanffy, was adapted to family systems. This theory created a unique perspective for understanding symptoms. The third development was research into the area of schizophrenia. During the 1950s, three independent research teams (led by Gregory Bateson at the Mental Research Institute in California, Ted Lidz at Yale, and Murray Bowen at the National Institute of Mental Health) all arrived at a similar conclusion: There is a strong relationship between family processes and the development of schizophrenia. Each team developed different explanations for this correlation, but the basic conclusion helped open the door to family therapy for the treatment of disorders previously believed to be solely intrapsychic conflicts. Fourth, the areas of marriage counseling and child guidance emerged early in this century and provided a foundation for family therapy later in the 1950s. Finally, there was the beginning of group therapy approaches, which had emerged around 1910 as a new treatment approach. The extension of group principles to families (a natural group) was a logical step.

Family therapy is approximately 60 years old. The first three decades could be characterized as the foundational years. Many family therapists, beginning as physicians or researchers, began to question traditional individually oriented approaches. Several treated families without interacting with other professionals for fear of ostracism. Researchers began to speculate about the nature of the relationship between family dynamics and intrapsychic pathology. During the 1970s, family therapy proliferated and diversity emerged. Several camps of theories and therapies developed including Inter-generational (Bowen, Boszormenyi-Nagy, de Framo, Paul, and Williamson), Behavioral (Stuart, Jacobsen, and Liberman), Structural (Minuchin and Aponte),

Strategic (Watzlawick, Haley, Madanes, Hoffman, and Papp), MRI (Bateson and Jackson), Milan Systemic (Selvini-Palazzoli), often placed within the strategic school of therapy; and the Experiential (Whitaker and Satir). The late 1970s and 1980s were characterized by divergence and specialization. Family therapists worked in many clinical settings, with a wide variety of problems, integrating family therapy with individual therapy, addictions recovery, and medicine. Family therapy became more integrated into the broader mental health culture. During the 1980s and 1990s approaches were added, which have been labeled *postmodern*, *narrative*, or *constructivist*. These include Solution-Focused (de Shazer), Narrative (White and Epston), and competency-focused (Waters and Lawrence). These additions engage families to activate their internal resources and competencies to create unique solutions or even to reconstruct how they interact with difficult problems. In the past 15 years there has been more development of increasing the focus on "depth" and "breadth" approaches. Affective depth strategies such as Internal Family Systems (Schwartz) or Emotionally Focused Couple and Family Therapy (Johnson and Whiffen) address the core emotional issues between family members. Breadth approaches such as Medical Family Therapy (McDaniel, Doherty, and Hepworth) utilize a biopsychosocial approach to include the biological and community impacts on families.

The first journal in the field, *Family Process*, was started in 1962. Today, there are well over a dozen journals and hundreds of books published on family therapy. A unique publication, the *Family Therapy Networker* (now named the *Psychotherapy Networker*) provides discussion of topical issues and is an excellent resource for upcoming workshops and seminars. The American Association of Marriage and Family Therapy (AAMFT) publishes a clinical/research journal, the *Journal of Marriage and Family Therapy,* and a professional magazine, the *Family Therapy Magazine*, which keeps readers informed about national clinical trends and legislative efforts in the field. The journal of the Collaborative Family Healthcare Association, *Families, Systems, and Health* focuses on the interaction of health-related issues and families. This journal often has articles that look at treating the health issues of children and adolescents. There are several dozen family journals published all over the world, including Britain, Australia, Japan, New Zealand, and Finland. The International Family Therapy Association's journal, the *Journal of Family Psychotherapy*, focuses on clinical and training advances worldwide.

There are several professional associations for family therapists. The AAMFT is the largest (about 24,000 members) and serves to set the standards of the profession in the United States and Canada and to promote the profession. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) was established by AAMFT in the 1970s. The COAMFTE is officially recognized by the Federal Department of Education as the accrediting organization for marriage and family therapy training programs. There are more than 100 programs accredited in North America to teach

marriage and family therapy. The second main organization, the American Family Therapy Academy (AFTA), is an academy of advanced professionals—a think tank composed of approximately 500 members who meet yearly to share ideas and to develop common interests. There are now several others including the International Family Therapy Association, the California Association of Marriage and Family Therapists, and a specialist section within the National Council on Family Relations, the Association of Family Therapy and Systemic Practice within the United Kingdom.

OVERVIEW OF THEORY

In describing the theoretical differences between systemic or interpersonal therapies and intrapsychic therapies, the metaphor of a camera is often used. In individual therapies, the lens is focused on the thoughts, feelings, or experience of the client. In all approaches to family therapy, the lens is widened from the individual to the relational context in which individuals live: primarily the family. However, family therapy approaches differ in terms of their specific focus on observations, hypotheses, and interventions. This section provides an overview, and highlights the important theoretical components of several widely used systemic approaches.

Structure and Organization—Structural Family Therapy

Emphasis on the structure and organization of family systems is a crucial factor in the approach developed by Minuchin (1974). Three key structural concepts are: *subsystems*, *hierarchy* (guidance and leadership), *boundaries* (closeness and distance), and *development* (normal changes in development over time).

Subsystems in a family are individuals, dyads, or larger groups who make up a subset of the family. While some subsystems are natural (e.g., the parental team or sibling group), there are others unique to a particular family. For example, a mother and youngest child can form a subsystem such that everyone else is excluded. From the formation of this alliance or coalition, problems may develop. A therapist evaluates the function of the family in terms of hierarchy, roles, and boundaries (interrelationship rules) of these subsystems, as well as of the whole family.

All systems, including families, need to maintain some *hierarchy and leadership* to move through normal developmental stages as well as manage acute crises. This usually involves the adults being able to make decisions that are in the best interests of the children and the family. A common problem described in adolescence is an *inverted hierarchy* (Haley, 1980) in which adolescents are directing their parents. Another is when adults abdicate family leadership duties and covertly require children to take on adult roles within the family; this is commonly referred to as a *parental or parentified child* (Haley, 1987). The latter can be differentiated from appropriate childhood chores,

like babysitting younger siblings, because in appropriate circumstances the adults maintain the authority of making the rules, the child's responsibilities are clearly delineated, and the child receives overt support and direction from the adult.

Boundaries are invisible barriers, often compared to cell membranes that surround individuals and subsystems and regulate the amount of closeness within itself and with other subsystems. Boundaries can be described as internal: between family members/subsystems, or external: between family members and their neighbors, friends, or school. If boundaries are thin or loose, closeness is emphasized over autonomy. If the boundaries are thick and rigid, the reverse is true. Culture, geography, mobility of the family, political climate, and neighborhood safety are just a few of the larger systems dynamics that can influence how permeable and flexible boundaries are within and around a family. Minuchin (1974) described boundaries on a continuum between rigid and diffuse. Rigid boundaries are overly restrictive and permit little contact with other family subsystems or external systems. Families with rigid internal boundaries tend to be disengaged from each other. Children in such families often feel isolated or neglected. "Acting out" problems like conduct disorder can be more prevalent. On the other end of the continuum, families with diffuse internal boundaries tend to be enmeshed (e.g., overly supportive; may learn to rely too heavily on each other). "Acting in" problems like anorexia and depression can result. Families with rigid external boundaries tend to create overdependence on each other and isolation from others. In families with diffuse external boundaries, it is difficult for family members to feel connected with each other. The important contribution of a structural assessment to a unified theory is its focus on organization, particularly concepts of hierarchy (who is up and who is down) and boundaries (who is in and who is out). It enables a therapist to see strengths that can be emphasized with a family (you have developed a very close bond with your daughter), as well as identify themes for therapy and change. (In addition, it will be important for her to develop some ability to handle disappointment on her own.)

Family Development

Another structural component to consider is its stage of development. Individuals go through various stages of development, and families can be seen as doing so as well. Even as family structures have changed over the past several decades, there are still predictable times of transitions—stages—as a family moves through time. McGoldrick and Shibusawa (2012) suggest that the "central underlying processes to be negotiated are the expansion, contraction, and realignment of the relationship system to support the entry, exit and development of family members in a functional way" (p. 385). They propose the following stages of the family life cycle: young adulthood; coupling/marriage; families with young children; families with adolescents; families at midlife—launching adult children; and the family in later life. These predictable transitions alter the family

structure (boundaries, hierarchy) and/or require a shift in the ways the family members relate to each other. In addition to these predictable transition points, there are unpredictable, yet not uncommon, events that also require a shift in family structures, roles, and boundaries. Accidents, illnesses, unemployment, natural disasters, divorce, and remarriage can lead to disequilibrium and reorganization of roles and boundaries. Individuals within families may exhibit emotional, behavioral, or medical symptoms if the family lacks the flexibility to accomplish the tasks of reorganization necessary to accommodate the new stage of development.

The Feminist Critique of Structural Family Therapy

In the mid-1980s, there was a reaction against the mechanistic way that therapists, particularly structural therapists, described families. The critique was that this approach did not take the interpersonal and historical aspects of gender, class, and culture into consideration. The conceptualization of the overinvolved mother and the peripheral father was seen as another way of collaborating with sexist, patriarchal social rules by pathologizing the mother and bringing fathers to the rescue. Feminists contended that mothers were overinvolved and insecure, not because of some personal flaw, but because a sexist society had delineated emotional and relational work as invisible, not valuable, and feminine, which left women emotionally isolated and often in economically dependent positions. This was a product of a sexist historical process hundreds of years in the making (e.g., Goldner, 1985). These writers and therapists contended that it was important to look at gender roles as being limiting for both males and females, and to challenge both to be part of the solution. They saw an unconscious bias toward viewing mothers as having the major responsibility for child rearing and housework at the expense of their own careers and lives (Anderson, 1995). They encouraged therapists to examine their own biases; and their implicit beliefs about roles, duties, responsibilities, and rewards in regard to both men and women (e.g., Goldner, 1991; Hare-Mustin & Marcek, 1988; Silverstein & Goodrich, 2003). More recently, feminists have demanded that therapists also look at their racist and heterosexist assumptions and families' culturally congruent traditions that support taking responsibility for both women and men to be engaged in emotional and practical family work (e.g., Hays, 1996; Killian, 2003; Long & Serovich, 2003; Mac Kune-Karrer & Weigel Foy, 2003; Pearlman, 1996; Pinderhughes, 2002; Tamasese, 2003; Tien & Olson, 2003; Tubbs & Rosenblatt, 2003). The concept of intersectionality (Prouty, 2014; Silverstein & Goodrich, 2003) facilitates therapists' examinations of how power intersects with gender, culture, class, sexual orientation, relationship orientation, country of citizenship, age, physical ability, immigration history and many other aspects of identity. This way of looking at intersections helps therapists to think about how each aspect of their identity enables or provides

barriers to social power. Intersectionality also encourages therapists to think about how identity and access to power both change as a person's context changes (Hernández & McDowell, 2010; Prouty, 2014).

Interactional Patterns—Strategic Family Therapy

A second aspect of family functioning is the actual problem-maintaining sequences of behaviors or patterns of interactions. If the sequences that maintain the symptoms can be changed, then the symptom is no longer necessary. Thus, symptoms are viewed as maintained by and simultaneously maintaining repetitive cycles of interaction. Patterns of interaction are redundant sequences of behavior that may recur across many different content areas. For example, a mother is talking to her oldest son when her daughter interrupts. The father criticizes the daughter for interrupting and the mother criticizes the father for being too harsh. The son gets upset about being ignored and leaves the room. This simple pattern may be repeated over and over in this family, utilizing different topics to begin the sequence.

In addition to interactions, rules and roles become part of symptom maintenance. Rules govern power, division of labor, and patterns of interaction in a family. Some rules are overtly stated (e.g., a rotation of dishwashing or taking out the trash). However, many family rules are covert and not talked about openly, for example, going to your room when your parents are fighting or not talking to a parent who has been drinking. Roles are a natural extension of rules. For example, the mother may be the nurturer, the father the disciplinarian, the oldest son the hero, the second son the troublemaker, and youngest daughter the cute peacemaker who makes everyone laugh.

When these patterns prevent the system from accomplishing its tasks, symptoms may develop. The symptomatic behavior (e.g., a child refusing to go to school) is dysfunctional from the school's point of view, but may be logical within the interpersonal network of the family. If the parent of such a child is depressed and suicidal, the child's "protective" behavior may serve to stabilize the system. Thus, the symptom is adaptive for the family.

In their book *Change, Principles of Problem Formation and Problem Resolution*, Watzlawick, Weakland, and Fisch (1974) emphasized that families are always trying to adapt and adjust to changing circumstances while also trying to avoid change and its uncertainties. Thus, when confronted with normal life difficulties, families found solutions to resolve their ambivalence about change. It is these solutions that become the presenting problems. If the system, or individuals within them, can create new solutions that do not turn difficulties into problems, the symptom will no longer exist. These new, problem-free solutions require the system to create new rules, and thereby a slightly different system. This form of change is called *second-order change* because *morphogenesis* is required.

However, the families with whom therapists work have often attempted to solve their own problems, but have instead substituted problems for problems: This is called *first-order change*. Watzlawick et al. (1974) focused on three common types of solutions families construct for difficulties that then become problems and rigid problematic sequences. The first are those in which some action needs to be taken, but the family does not act. An example of this type of problem development would be failure to alter parenting style as a child becomes an adolescent. This can result in increased rebellion and power struggles. A second way problem sequences develop is when actions toward a difficulty are taken when there is no need to do so. These are situations where the solution or cure becomes the problem. A couple who has the idea that they will always insist on strict obedience from their children may create a negative environment by their constant action and unwillingness to pick their battles carefully. The third way problematic sequences develop is when there is a problem and an action is taken, but it is at the wrong level of intervention. For example, parents may try to cheer up an adolescent who is depressed. When these attempts do not succeed, the parents may try harder with more of the same actions. The result can be an increasingly withdrawn and angry teenager who feels controlled and manipulated. Both parents and child can become engaged in a pattern that does not relieve the symptoms, but actually leads to their increase as a consequence of the misdirected solution. (For a more complete discussion of first- and second-order change, see Keeney, 2002).

Belief Systems—Changing the Meaning

An important factor affecting the development of structure and patterns in a family are their belief systems. The basic theoretical premise of this view is that family members attribute meaning to behavior within a context and the meaning becomes more important than the behavior. For example, one family may define a child's behavior as cute and amusing while another family may define similar behavior as unacceptable. Behavior is far less significant than the meaning attached to it. Behavior is also analyzed through the context in which it occurs. Similar behavior may take on different meaning in different contexts. A child interrupting a parent at a social gathering may elicit punishment, whereas a child interrupting a parent to warn of an approaching danger may be praised. The interpersonal context in which behaviors occur is crucial to a systemic therapist. A child may behave very differently at home when one parent is present compared with when both parents are present. School behaviors may be totally different than those at home, and certainly behavior with peers may be even more diverse. An analysis of as many settings as possible to discover what happens when and who is involved is important in developing hypotheses about the problem and designing interventions.

Family beliefs are constantly evolving. Problems develop when previous beliefs do not fit the current situation. Moreover, problems develop because of the meaning families

attribute to the situation. If new information can be given to family members to help them understand their behavior in a new way, change can occur.

Circularity

Circularity is a key concept in all family therapy approaches but was most central to the Milan, MRI, and Ackerman groups. The belief systems of family members are usually linear, that is, they explain events as *cause-effect phenomena*. Steve did this; then Jenny did that. However, to understand the nature and impact of a family's belief system, a circular view of events must be employed. Circularity is the concept that problems are maintained by patterns of interaction between people that have no clear beginning or end. Circularity maintains a focus on present patterns and emphasizes the reciprocal nature of behavior, thus including all family members in a problem. Behavior problems in a child are not thought of as being caused by poor self-esteem or divorcing parents. Circular thinking does not permit individuals in the family to be identified as villains or heroes. There is no extensive search for the cause of a child's misbehavior, only a clear description of what maintains it in the present. In fact, there is a search for positive intention and competency to assist family members in seeing the story in a more positive light. A circular hypothesis examines the relationship between the system and the symptom and provides for interventions that impact the entire system.

Beliefs define the rules, roles, interaction patterns, and structure of the family, while these in turn define the family's belief. The interdependence of these relationships is graphically depicted in Figure 9.1. For example, if a parent believes her child cannot be trusted, she may overcontrol the child's behavior, thus making it difficult for the child to learn how to respond to different situations. If the child is given some freedom and

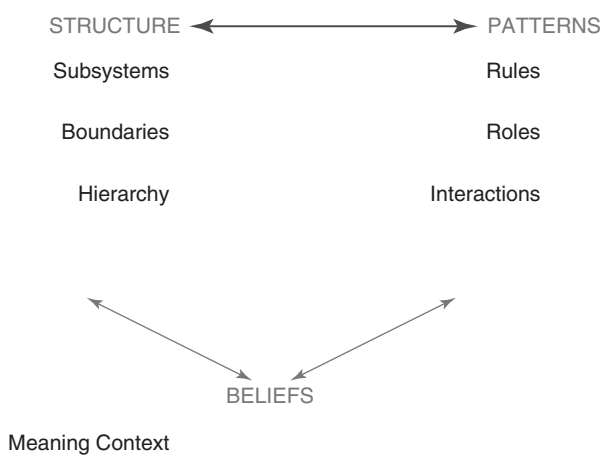

Figure 9.1 Important components of overview theory.

acts in a way that displeases the parent, her belief that the child is not trustworthy will be reinforced.

Solution-Focused Therapies

Solution-oriented and solution-focused therapies (de Shazer, 1991; O'Hanlon & Weiner-Davis, 1989) represent collaborative, postmodern frameworks that also focus on families' belief systems and the meaning the families attribute to the problems for which they seek help. However, unlike the general systemic therapies mentioned previously, the emphasis is on finding solutions rather than understanding the problems. Another distinction between solution-focused therapies and other systemic therapies is the underlying assumption that families do want to change, and that individuals have their own perspective. Therefore, the concept of right or wrong is not a useful one (with obvious exceptions like violence). For the most part, problems are considered to be a part of everyday experience rather than a sign of pathology. Clients are considered experts on their own experience. The therapist's job is threefold: (1) to acknowledge and validate the clients' experience; (2) to guide clients as they shift either their behavior (what they "do") related to the problem or their perceptions (how they "view"), the problem; and (3) to build on the clients' existing strengths and resources.

Narrative Therapy

Similar to solution-focused therapy, narrative therapy represents a collaborative, postmodern framework. Narrative therapy is part of the social constructionist movement of family therapy, which describes reality as constructed through interactions and conversations with others (White & Epston, 1990). Michael White and David Epston's theory of narrative therapy is based on the work of Michel Foucault, a French intellect who wrote about constructed ideas having influence on people's lives (White & Epston, 1990). White and Epston (1990) propose that the meanings and beliefs of families are constructed through multiple personal, sociopolitical, and cultural life stories. These dominant stories impact family functioning and have the potential to maintain problems within the family system.

Narrative therapy (Freeman, Epston, & Lobovitz, 1997; Marner, 2000; Smith & Nylund, 1997; Vetere & Dowling, 2005) suggests that each of us has the ability to externalize and question the old, dominant stories, and to generate new stories about the past, the present, and the future. Narrative therapy emphasizes how language plays a vital role in creating meaning, and that the act of naming aspects of our clients' lives gives validity to experiences. Problem-saturated stories become the background as children, teens, and their families begin to notice unique outcomes and sparkling moments in which they live together without the problem dominating their lives.

Newer Theories—Focus on Depth and Breadth

Internal Family Systems

Richard Schwartz (1997) developed the Internal Family Systems (IFS) model after working for many years with adult clients struggling with trauma and eating disorders. The IFS model begins the idea of the multiplicity of the mind (e.g., part of me thinks this, yet another part of me wants that) and then applies basic systems and structural family therapy concepts, enabling clients to understand and access their own internal system. The ideas of boundaries, structure, homeostasis, negative and positive feedback are all essential therapeutic concepts with family systems, as well as when addressing the internal systems and subsystems using the IFS model. Like with many other systemic models the concepts of balance, harmony, leadership, and development are extremely important (Schwartz, 1997).

Within the IFS model persons have many subpersonalities, called *Parts*, that are ideally mediated through a central Self. In IFS, the Self is the conductor or coordinator, "the I" (Schwartz, p. 37), and is a person's compassionate core. The Self provides clarity, perspective, and empathy for both oneself and for others. Being in the Self provides the sense of peace and of being centered; it is the "seat of consciousness" (p. 40). As people experience life they develop personality Parts. Some of the Parts perform one of three specific roles: exiles, managers, and firefighters. Exile parts are most commonly developed during traumatic experiences. They contain memories and extreme emotions such as helplessness, shame, and terror. They arise in situations, often in childhood, when a person is without power to escape or protect oneself. When re-experiencing these memories and/or emotions is overwhelming, these parts are internally exiled, tucked into an internal closet. Thus, exiled parts are a primary example of the internal system trying to maintain homeostasis and harmony, but doing so in an extreme and unbalanced way. What is important to note here is that exiled parts are usually excluded from the person's cognitive and emotional development. Keeping these parts exiled, and hidden from the Self requires a lot of internal energy. This energy is funneled into developing parts whose job it is to maintain the exiled part's banishment. The first of these parts is called a *manager*. Like the name suggests, managers are usually the cognitively and emotionally methodical parts. In their pursuit of an exile's banishment they can grow too powerful, and their development is stymied due to their narrow focus. The rules of the internal system cannot evolve. Managers can range from functional to extreme. For example, a manager can be a part that is superorganized but can grow too extreme by exhibiting symptoms of obsessive control, such as "perfection," or someone who is too focused on validation from others. Sometimes it is so extreme that managers supersede the Self, throwing a person's internal system out of harmony in an effort to rigidly maintain a homeostasis of the exiled part, but prevents both consistent Self-leadership and

normal internal system maturation. When managers are unable to reliably maintain an exiled part's banishment or when there are several exiled parts, a more extreme part can develop. Firefighters have the same goals as managers, but have more extravagant methods that often have distraction or appeasement of the exile's emotional terror at their core. In this way their aim is internal system homeostasis, but their methods are extreme and usually dangerous. Often firefighter tactics are extreme enough to warrant a mental health diagnosis, such as an addiction, an eating disorder, or violent behavior. Firefighter tactics may seem irrational to outsiders, but once the internal system is understood, the rules of parts' roles and homeostatic dynamics can become clear.

The role of the IFS therapist is to help the client understand her own parts—and one's partner's parts in couple therapy. Balance, harmony, Self-leadership, and continued development are the goals. Therapists work from a strengths-based, empathic position that evolves from Self-directed leadership within their own internal systems. Several articles (e.g., Johnson & Schwartz, 2000; Wark, Tomas, & Peterson, 2001) and books (e.g., Sweezy & Ziskind, 2013) are available, as well as official training seminars (www.selfleadership.org) if one wants further training in Internal Family System's therapy. What is important to note is that this model can be used at many levels, and most of the interventions from other systemic intervention models can be used to help a person find the strengths and resources to develop Self-leadership, rebalance one's internal system, and to help partners to be in charge of how their internal systems interact. IFS can be done with individuals and with more than one person in the room, such as with couple therapy.

Medical Family Therapy

Medical Family Therapy (MedFT) was first described as a theoretical model in 1992 in a book by Susan McDaniel, Jeri Hepworth, and Bill Doherty. The second edition of this book was published in 2013. MedFT is based on the biopsychosocial approach outlined by George Engel (1980). It expands family therapy concepts to include looking closely at the biological system of physical symptoms and diagnoses and how this interacts with family relationships and the relationships between the school and the family. Several graduate training programs in family therapy now focus a large part of their curriculum on this model and set of techniques. For children, adolescents, and their families it provides a way of thinking about the interaction of chronic medical conditions in the child or another family member that helps in understanding problematic behaviors and patterns in the family. It strongly encourages developing close collaboration between primary care medical providers, schools, behavioral health providers, and the family in creating a joint treatment plan.

GENERAL THERAPEUTIC GOALS AND TECHNIQUES

In the space available in this chapter, it is impossible to describe all the techniques developed from systemic theory. In this section, we briefly outline a few that correspond to the theories of family functioning described earlier: Structural, Strategic, Belief systems, and the postmodern approaches of the Solution-focused and Narrative therapy models. Interventions from directed play therapy, Internal Family Systems therapy, and Medical Family Therapy are also provided. The interventions therapists choose depend on their own theory of change and the fit for the family as the therapist can determine which of the family experiences may be more helpful on which to focus.

Structural Interventions

With a structural emphasis, a therapist joins with the family, maps structural dynamics such as hierarchy and boundaries, and has the family enact patterns that give them new possibilities for alternative relationships. Minuchin and Fishman's (1981) book *Family Therapy Techniques* provides detailed descriptions of interventions into the structure/organization of the family. Salvador Minuchin is still practicing and writing and runs the Minuchin Center for the Family in New York City. In his most recent book, *The Craft of Family Therapy: Challenging Certainties* (Minuchin, Reiter, & Borda, 2013), he emphasizes the therapist's use of self as the key change agent regardless of the techniques used. This ability to "roll up your sleeves" and connect with the family on a personal, affective level is key to seeing patterns and making change happen. Structural family therapist, David Waters, in Charlottesville, Virginia, trains therapists in regard to structures and patterns: the key elements of therapy are to "See Them," "Name Them," and "Change Them."

Joining is a technique by which a therapist works to understand and accept each person's position in the family. The family often approaches therapy with some anxiety and guilt, and it is important to connect with each member. Failure to join and accommodate to the way things are may produce resistance to therapeutic interventions. Joining includes, but is not limited to, the initial session. It occurs throughout therapy and does not always mean listening and being nice. Often it involves saying something that is painful, but real in the experience of one or more family members.

Mapping the family structure involves two stages. In planning for sessions, the therapist makes some hypotheses about structure, asking questions such as: Who seems most powerful? What relationships might be disengaged from each other? Is the hierarchy functional? These questions or hypotheses continue to be generated throughout therapy. The second stage of mapping involves testing these hypotheses by watching the family interact as well as talk to each other.

As opposed to spontaneous behavioral interactions in which families produce a sample of problematic exchanges within the therapy session without any suggestion from the therapist, enactments involve asking the family to provide an example of the problem or to talk about difficult subjects, or to try a different interaction during the session in front of the therapist. Both spontaneous interactions and enactments can be used to highlight or modify interactions by encouraging family members to unravel covert rules that are sabotaging constructive interactions or to behave in new, competent ways that will lead to new rules for relationships and people's roles within their family. For example, a mother and daughter who are in a constant battle for control may be asked to engage in a different kind of interaction. In a soft tone, sitting in close proximity to the mother, the therapist may ask the mother to talk in a soft tone, sit next to her daughter, and talk to her about her concerns for the daughter's safety.

Pattern Interventions

An emphasis on changing the patterns of interaction involves different kinds of interventions. The therapist is more interested in changing the symptom maintaining sequences than on changing the structure. Precise questioning about the process occurring around the problem and attempted problem solutions is important. Tasks are often assigned to alter these sequences.

The questions asked in the initial interviews revolve around who does what, how, and when the problem occurs. This not only provides information about the process, but also about the possible functionality of the symptom for the overall system. Haley (1987) provides an excellent description of such an initial interview.

In these initial sessions, family members present their view of the problem and of the solutions that have been tried. It is these solutions that often are addressed by therapeutic interventions. After a clear problem definition is agreed on, the family and therapist set goals for therapy. This is often the most difficult phase of therapy. Presenting problems, such as we want to communicate more, tend to be vague and families have more ideas about what they do not want than what they do want. However, in order for the strategically designed interventions that follow to be effective, this problem definition/goal setting is crucial.

Assignment of tasks to be completed outside of the sessions, homework, is a primary intervention utilized by therapists focused on altering patterns. Tasks can be direct or paradoxical. Straightforward directives are given with a rationale designed to correspond to the goals agreed on in the initial sessions. If therapeutic rapport is developed and resistance to change is low, the family will be able to carry these out. Attention is paid to the way in which families carry out the assigned tasks. Their level of resistance to change can be gauged by whether they carry out the task exactly, modify the task, or fail to do it at all.

Paradoxical interventions are designed to counter strong resistance to change (Watzlawick et al., 1974). The usual method is to ask the family not to change, to go slow in changing, or to continue the symptom. These directives are given with the intent that the family will be placed in a bind. If they follow the directives, they are exercising control over these symptoms. If they do not comply, the symptoms change. These interventions have been extremely controversial with proponents arguing they are congruent and respectful of the family's fear of change while others argue that they are tricky and manipulative. The key variable seems to be the rationale that accompanies the directive and the degree to which the therapist believes it to be true. If paradoxical interventions become routine statements used in every case, they are not likely to be as effective as if they come out of the family's efforts in therapy, and are designed to have unique meaning to the family. In addition, Cloe Madanes (1981) described another type of paradoxical intervention. She advocated the use of "pretend" techniques to playfully confront destructive patterns. For example, a symptomatic child is asked to pretend to have the symptom and the parents are encouraged to pretend to help. The child can give up the actual symptom because pretending to have it is enough. You cannot pretend to have a phobia or throw a tantrum and have a real one at the same time. The family then readjusts its patterns of interaction without the child needing to maintain the symptom. The intervention can turn a deadly serious struggle that would not respond to a direct approach at change into a playful make-believe game. It is also useful with children because it involves play and pretend.

Belief System Interventions

Although the focus on structure and patterns emphasizes behavior change first with a belief change to follow, the systemic therapists emphasize belief or meaning change as the primary target. Three interventions from this approach are *reframing* (Watzlawick et al., 1974), *circular questioning* (Nelson, Fleuridas, & Rosenthal, 1986; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1977; Tomm, St. George, Wulff, & Strong, 2014), and *family rituals* (Imber-Black, Roberts, & Whiting, 2003).

Reframing is an intervention used often by family therapists. The therapist hears the situation as presented by the family and then restates it in a new way. The goal is to change the way reality is perceived so that new behaviors will follow. For example, an anorexic girl who is seen as sick by her parents and in need of a great deal of tender loving care can be reframed as being disobedient and in a power struggle with her parents. A delinquent boy can be viewed alternatively as sad and insecure who is in need of firm structure and guidance to feel secure. As with the paradoxical directive, these restatements of the problem must be unique to the particular situation and not seen as standard and to be used in every case. Positive connotation (Selvini-Palazzoli et al., 1977), a form of reframing, always defines symptomatic behavior in terms of its

helpfulness to the system. For example, a child's misbehavior may be redefined as helpful to her parent's communication.

Circular questioning is a technique that has received a lot of attention in the clinical literature. This form of questioning serves as an efficient process for soliciting information from members of the family regarding their opinion and experience of (a) the family's presenting concern; (b) in what context the behaviors occur; (c) sequences of interactions, usually related to the problem; and (d) differences in family members' relationships over time. All family members are asked questions such as: Who is the most upset when John throws a temper tantrum? Who feels the most helpless when it happens? The answers are used to generate additional hypotheses about family functioning or additional questions. The questions themselves are seen as interventions in that they may provide the family with new information about the way things are now and the way they could be in the future. New belief systems that necessitate new behaviors by family members can be created. Such an approach to opening space for multiple realities is also helpful when gay and lesbian teens first come out to their families (Stone-Fish & Harvey, 2005).

A therapist can prescribe a *family ritual* (Imber-Black, 2003) that is usually a complex, elaborate task involving all family members. The therapist asks the family to complete an action or series of actions sometimes accompanied by verbal expressions. The ritual is prescribed in every detail: the place it must be carried out, who must say and do what action, and the number of times the ritual is to be completed. Often, the instructions are given in writing and the session is ended without further discussion about the assignment. A particular ritual is designed for a family after careful consideration of the unique rules that maintain their problems. The ritual breaks these rules in some way and the family can experience an alternative belief about themselves.

Rituals are different than strategic ordeal interventions because ordeals are usually absurdly detailed home enactments of the problem aimed at helping families to substitute healthier interaction patterns in order to replace what the symptom originally provided. Rituals, however, are overt and positive reworking of a family's identity, enhance cohesion, and facilitate transitions through the life cycle.

Solution-Focused Therapy Interventions

Solution-focused and solution-oriented therapies rely on conversations using ordinary language. Rather than getting mired in how the problem developed, the conversations are directed toward what will be different and better when the problems are solved: The therapy is present- and future-focused. Sometimes it is difficult for a family, who may be discouraged, to envision a life without its problems. One particular strategy that is used by these therapists repeatedly is the *miracle question:*

> Suppose that one night there is a miracle, and while you were sleeping, the problem that brought you to therapy is solved. How would you know? What would be different? What will you notice different the next morning that will tell you that there has been a miracle? What will your spouse notice? (deShazer, 1991, p. 113)

With the family's newly defined, problem-free, and future-describing goals in mind, conversations may concentrate on exceptions to the problem. For example, with a family who has concerns about a child having temper tantrums when being dropped off at school, the therapist might ask, "Tell me about a time when she did not have a temper tantrum when you dropped her off somewhere," and go on to explore in great detail every aspect of that experience, encouraging members of the family to identify what they did to contribute to that success, asking explicitly how each decided to do something different.

As clients tell their stories, the therapist may highlight and punctuate differences or distinctions from the way they handled a similar situation in the past (Dym, 1995). When a family seeks help with a child who throws temper tantrums, the therapist may hear about some efforts to solve the problem: instead of trying to sneak out of the classroom, the parent stayed in the classroom a few minutes; or that instead of the mother taking the child to school, the father did. Even if the child still had a temper tantrum, the therapist's interventions would include many observations and questions about the attempts at doing something different. If, in fact, these differences did lead to a different outcome, clients are encouraged to "do more of the same."

Often when a family is experiencing a problem, family members become so focused on that one issue that they neglect areas of the family functioning that are going well. One way to move the family away from the negative focus is to ask what is going well: what do they want to continue doing or even do more of (de Shazer, 1985)? Another technique that inserts some hopefulness is to ask scaling questions; asking clients to rate the problem on a scale of 1 to 10. This offers the opportunity to discuss the "degree of" the problem rather than a simple "problem/no-problem" dichotomy. The therapist can ask questions around these degrees: "Why a 3 and not a 2?" and "What would have to happen to make this a 4 or even a 5?" Scaling solutions in increments toward the miracle question's outcome provides families with the opportunity to see incremental change and to witness how important it is that everyone contributes to positive change.

Solution-focused therapy is traditionally brief and ends when the original problem is no longer considered a problem, either because the family is doing something different or its view of the problem has shifted.

Narrative Interventions

One of the primary techniques used in Narrative therapy is externalization of the problem as separate from the identified patient. *Deconstructing questions* help everyone in the family trace the effects of the problem on each person and their family as a whole. *Reconstructing questions* enable members to trace the ways they influence the life of the problem. Externalization, deconstruction, and reconstruction help all members of the family to take responsibility for their own contribution to the problem and for their role in positive change. Metaphors are established to guide the family to create change, like: "kicking out the chaos," "creating more cohesion and fun that are toxic to the depression," "learning from the anxiety so as to invite safety," or "building the courage." Narrative therapy also includes helping families to talk about sociopolitical forces that contribute to the problem, such as sexism, racism, heterosexism, or poverty. In this way, the family can work together instead of allowing social violence to separate them.

Narrative therapists often facilitate the change momentum by writing therapeutic letters to children, teens, and their families between sessions. Letter writing campaigns in which family members write narrative letters to each other, school or medical personnel write narrative letters to the clients, or children write narrative letters to themselves also work well. In addition, children and their families may see themselves as part of a larger community that has dealt with similar problems (such as depression, anxiety, incontinence, an eating disorder, a chaotic system, or racism) and receive comfort from the normalization of their experience and pride in overcoming the problem.

New Approaches

Directive Family Play Therapy Interventions

Eliana Gil (1991, 1994) and Nancy Boyd-Webb (2007) brought concepts from play therapy into systemic family therapy practice. Systemic family therapy ideas and models have been enriched with concepts from child development, play theory, and trauma theories to provide a rich and useful basis from which to help children and their parents understand and resolve the effects of trauma, major transitions, and childhood worries. In directive play therapy the therapist uses puppets, art, clay, dollhouses, toys, and a sandtray to enter into the children's perspective. Commonly used interventions include the family puppet interview in which the therapist asks the family to take 15 minutes to construct a story with a beginning, a middle, and an end. The family then performs the play for the therapist and the therapist enters into the family's system through the puppet's story. Another method of entering the family system through play is to have the family take turns drawing a story. The story can be random or it can be about a particular time of day that the therapist would like to know more about: like how does bedtime work,

or what do family dinners look like. (for more details about both of these interventions see Gil, 1994).

Internal Family Systems Therapy Interventions

If the Self seems to be constrained by an unbalanced group of parts, such as an overzealous manager or impulsive and destructive firefighter, therapy first focuses on identifying the benevolent motivations of the constraining parts. Schwartz and colleagues have developed specialized insight oriented and methods of inner work (Schwartz, 1997; Sweezy & Ziskind, 2013). Because of the strong influence of systemic thinking and structural family therapy on the IFS model, many therapists apply systemic and structural interventions (usually direct but occasionally paradoxical strategic) on the internal parts of the system to discover the internal dynamics, patterns of interactions, and belief systems of this internal system. Narrative- and solution-focused interventions can be used, also. The main difference is that unlike some democratic systems, the IFS model is focused not only on harmony and balance but on a strong and benevolent Self-leadership of the internal system. Once the Self is recognized, the parts are identified, and the internal patterns and beliefs are known, the therapist works to help the client to de-constrain the Self, return exiled parts into the system, deflate overextended managers, and change firefighters into constructive members of the internal system. Several books and journal articles are available and training seminars are offered all over the world if a therapist wishes to be trained on the model and interventions.

IFS Interventions with Children

Children should at least be in concrete operations (Piaget, 1977) because in this stage they can first concentrate on more than one thing at a time: a process called *decentration* (Rathus, 2008). Whether in individual or family therapy, using a simplified version of IFS and more visual and concrete interventions like puppets, drawing, and sandtray to access what different parts might want, do, and feel makes accessing parts easier.

IFS Interventions with Adolescents

In using IFS therapy with teens, especially those whose cognitive development has moved from concrete operations into formal operations (Piaget, 1977), the therapist should note that it is common for teens to have several new parts under development. Once in the formal operational stage people are capable of deductive reasoning, hypothetical thinking, and greater empathy for themselves and for others. Therapy using IFS can now focus on helping the adolescent to achieve a Self-connection with minimal interference and maximum support from all one's parts. Therapists can help clients to identify, understand, know, and have empathy for all of their parts. By working from a

Self-leadership position clients rebalance their internal system. Internal work (Schwartz, 1997) through internal and externally lead discussions, journaling, and art-based insight therapeutic work are all possible with adolescents alone and with their families.

Medical Family Therapy Interventions

It is often very difficult when a significant chronic medical condition enters into family life. A teenager who is diagnosed with Type 1 diabetes, a child with significant anxiety and bladder/bowel problems, a child with asthma, or a 17-year-old boy who is diagnosed with cancer several months after his parents were divorced are all examples of the kind of disruption caused by dealing with health and the health care system. All of these issues also affect the school environment as well. The current focus on "medical home" came from attempts to create for families a sense of continuity and clarity in a time of great uncertainty and significant time dealing with the health care system.

The kinds of interventions described in MedFT are as follows:

- Solicit the illness story from all family members. How did it develop? What are the greatest fears? Who does it affect the most? The least?
- Respect the natural defenses of both the patient and the family to deny the problem exists and to look only optimistically at the situation. Remove blame and accept any kinds of unacceptable feelings that are described by the family.
- Increase "agency" or family member's ability to make decisions and "go on with life" in the face of disability and uncertainty.
- Keep the illness "in its place," something to deal with but to not be overwhelmed by.
- Increase the connection between family members about the illness and between the family and the medical professionals working with them.

GROUP PROCEDURES WITH CHILDREN AND ADOLESCENTS

The family is a small group with a shared history. Therefore, family therapy may be considered similar to group therapy. However, an additional dimension of family therapy is multiple families in group programs. Three models of family group facilitation are described by Hoopes, Fisher, and Barlow (1984). Family education programs are primarily instructional in focus, with the expressed intent of imparting information and skills to family members. Parent education courses are a common type of family education program. One well-developed parent education program is Bavolek and Comstack's (1985) Nurturing Parent Program. This is a 15-week structured program designed to enhance parental self-esteem, parenting skills, social support, and overall healthy family functioning.

Family enrichment programs are designed to enhance skills and healthy family interactions through instructional and experiential activities. Two well-known programs, Understanding Us (Carnes, 1981) and Family Cluster (Sawin, 1979), bring groups of families together to share experiences, learn new skills, and develop healthier interactions. Enrichment and education programs provide knowledge and skills in a preventive spirit. They assist families in sidestepping or effectively coping with potentially difficult situations and, therefore, maintaining family integrity and cohesion.

Family treatment groups are designed to resolve problems encountered and developed by families and, therefore, are remedial in nature. Multiple family group therapy involves the treatment of several families together with regularly scheduled sessions. A common use of multiple family treatment is in chronic illnesses, addiction recovery (e.g., substance abuse), and eating disorders. Steinglass and colleagues have developed a comprehensive protocol for running these groups and have conducted research on their efficacy (Gonzalez, Steinglass, & Reiss, 1989). Multiple family groups for children with asthma or diabetes have also been run where the families can share both struggles and strategies that are helpful with each other.

In all three models, family members learn from the facilitator(s) and other families. All models offer a supportive context for the development of new roles and behaviors. In Hoopes et al. (1984), several tested enrichment, education, and treatment programs for families with children and adolescents are actually provided.

CLASSROOM AND EDUCATIONAL APPLICATIONS

Systemic theory applies as well to a classroom, a school, or an entire school system as it does to a family. Broadening the lens of analysis to include subsystems such as teacher/student, student/student, principal/staff, teacher/parents/student can help to provide a more organized way of approaching the problem as well as provide more options for intervention. Once this lens is widened, the choices for intervention can be on the structure/organization of the family, the patterns of interaction, the meaning/belief system, or possible solutions to the problems.

Children who are exhibiting behavior problems are often afraid of the power these symptoms have over adults. They may even escalate the problems to encourage adults to take charge. Teachers concerned about this escalation may call the parents in to a conference. After these meetings become adversarial, each looks to blame the other for the child's problem. Principals are sometimes present at these meetings, but either they are forced to support the teacher's position or they try to play a mediating role.

This school-family conference is an excellent example of a technique that focuses on the organization or structure of that system. The purpose of these conferences is to join with all family members and establish a clear leadership team between the adults.

Joining involves displaying a keen interest in knowing whether problems seen at school are observed in the home context and vice versa. This is done with curiosity about the differences between the two settings rather than projection of blame. One of the important benefits of these meetings is that the children are given a clear role to play. This depends somewhat on the age of the children, but generally, they are asked to observe the discussion and to provide input in a structured way when it is requested. The children thus observe the important adults in their life working together. More detailed descriptions of the possible structure of these interviews can be found in Fine and Holt (1983), Molnar and Lindquist (1984), Friedman (1969), or Winslade and Cheshire (1997).

A classroom can be thought of in much the same way as a family, with the teacher playing the same role as a therapist. In most therapeutic approaches, a child's misbehavior would lead to a focus on the child and an intervention designed to change the child's behavior. A systemic approach would enable the teacher to focus on his or her part in maintaining the problem behaviors. Outside consultants such as psychologists, social workers, or principals can help teachers to have that perspective and use systemic techniques in the problem.

Interventions can be made by focusing on the patterns of interactions that occur in a classroom. When teachers are able to look at their students and classrooms as systems, they are able to look at their own beliefs and behavior as part of that system. Instead of looking at the sequence of teacher yells and child disrupts or child disrupts and teacher yells in a cause-effect manner, both are seen as mutually determining each other. To the extent that the teacher yells, the child disrupts. To the extent the child disrupts, the teacher yells. This dyadic example could be expanded to include complex interactions between groups of students and teachers or administrators.

Another example involves a typical sequence at recess where one child is consistently being scapegoated into trouble by two other students. The teacher then enforces punishment on the scapegoat. If the teachers were to change their part of the pattern by intervening in a positive manner with all three students before recess, they might prevent their negative involvement later. This example enlarges the context to include the teachers and would require the teachers to embrace firmly the belief that they help to define roles played by the students. This is an alternative to the traditional belief that students are totally responsible for their own behavior.

Reframing, a technique described earlier, involves a focus on the belief system or meaning of the problem, or some aspect of it. Teachers can also use reframing. An angry, defiant child can be seen as extremely sad and desperately seeking to provide structure in his or her environment. Two children constantly fighting can be seen as attempting to work problems out in the only way they know how. Annoying children who are constantly sharpening their pencil can be seen as anxious to please and perform well on schoolwork. Teachers' responses to a child will depend in large measure on their belief

about the child's behavior. A teacher who sees a behavior as annoying is likely to become easily irritated and yell at the child. If the same behavior is seen as the child being anxious to please, the teacher may feel more compassion and patience for the child.

EFFICACY

As noted earlier, clinical research was one of the key movements that launched the field of family therapy. Since that time, several hundred outcome and process studies have been completed on a broad range of family problems, treatment approaches, therapist factors, and the effectiveness of family therapy. According to Gurman, Kniskern, and Pinsof (1986), by the 1980s research had come to occupy a truly significant and undoubtedly permanent place in the field of family and marital therapy.

Family therapy is inherently complex. While seeking to illuminate answers to what therapy is most effective for what problems, treated by what therapists, according to what criteria, and in what setting (Paul, 1967, p. 11), perplexing issues of target outcome variables, measurement, design, control groups, random selection, subject population, integration of research and practice are complicated by a systemic theoretical foundation. For example, targeted outcome variables may consist of increased healthy family functioning, increased individual functioning, and reaching the client's goal for treatment. With regard to increased healthy family functioning, how will this be defined, by whom, and how will it be measured? If increased individual functioning is the target variable, which individual(s) in the family is (are) measured? Regarding studies in which client goals are the outcome criteria, what about those families in which the members do not agree to a common goal? Despite these and other difficulties, researchers have provided studies that conclusively demonstrate the efficacy of family therapy. These studies have been notably reviewed by Gurman and Kniskern (1978, 1981), Gurman et al. (1986), Todd and Stanton (1983), and Sprenkle (2002, 2012).

In general, family therapy has been shown to be as effective or more effective than individual and other treatment approaches (Shadish & Baldwin, 2003; Sprenkle, 2002). Gurman and Kniskern (1978) examined 14 comparative studies (family therapy compared with other modalities) and found that family therapy was superior in 10 and equal in the remaining studies. Family therapy produces beneficial effects in about two thirds of cases. In fact, Gurman and Kniskern (1978) estimated the overall improvement rate for family therapy cases at 73%. Family therapy can produce positive results in treatment of short duration (1 to 20 sessions). Short-term or time-limited family therapy is as effective as longer-term therapy (Gurman et al., 1986; Todd & Stanton, 1983). The involvement of the father in family therapy substantially increases the probability of successful outcome (Todd & Stanton, 1983). In a meta-analysis on couple and family therapy interventions, Shadish and Baldwin (2003) found that couples and family

therapy approaches have been shown to be effective, and there is little evidence that one marriage and family therapy approach is superior to another. Marriage and family therapy can also cause deterioration in individuals and relationships. Deterioration rates (5% to 10%) for marriage and family therapy are roughly comparable to those reported for individual and group therapy. Gurman and Kniskern (1978) isolated certain therapist behaviors that were related to poor outcomes, including poor relationship skills, the confronting of emotionally loaded issues and defenses early in treatment, and little structuring of early sessions. More refined therapist skills seem necessary to yield positive outcomes. The age/developmental level of the identified parent (child, adolescent, adult) is not associated with treatment outcomes (Gurman & Kniskern, 1978).

With regard to specific disorders of childhood and adolescence, family therapy research has focused on psychosomatic disorders, juvenile delinquency and conduct disorders, and mixed emotional/behavioral disorders. The majority of the research in family therapy has focused on externalized childhood disorders, such as conduct disorder and juvenile delinquency, and fewer studies have examined the use of family therapy with children experiencing internalized disorders, such as depression and anxiety (Northey, Wells, Silverman, & Everett Bailey, 2003; Sprenkle, 2012).

Structural family therapy has been studied for the treatment of anorexia, diabetes mellitus, and chronic asthma. Minuchin, Rosman, and Baker (1978) reported an 86% improvement/recovery rate for 53 anorexics and their families. Minuchin et al. (1975) reported a 90% improvement rate for diabetes and chronic asthma. All three populations were treated with a structural approach. The Maudsley approach (a combination of Structural and Strategic family therapy) has been shown to be effective in treating adolescent anorexia nervosa (Eisler, Simic, Russell, & Dare, 2007). Brief Strategic Family Therapy, another therapy model blending structural and strategic interventions, was developed to treat the needs of Hispanic children in Miami, Florida (Szapocznik, Hervis, & Schwartz, 2003). Studies on this approach have demonstrated a reduction in conduct symptoms (Coatsworth, Santisteban, McBride, & Szapocznik, 2001) and greater improvement in behavioral problems (Santisteban et al., 2003).

Juvenile delinquency and family therapy have been extensively studied at the University of Utah by James Alexander and associates (Alexander & Parsons, 1973; Klein, Alexander, & Parsons, 1977; Parsons & Alexander, 1973) applying functional family therapy. Families treated with this approach significantly improved in communication and showed a lower rate of recidivism (26%) than other treatment modalities (47% for client-centered, 50% for untreated persons, and 73% for dynamic-eclectic therapy approaches). Barton, Alexander, Waldron, Turner, and Warburton (1985) extended the study to more serious juvenile offenders and found that the use of functional family therapy resulted in a 57% decrease in criminal activity at a 15-month follow-up. In more

recent studies on the use of functional family therapy, the results have been mixed, with no treatment effects shown when treating substance abusing youth (Friedman, 1989; Waldron, Slesnick, Turner, Brody, & Peterson, 2001). Patterson (1982) studied conduct disorders involving aggressive (e.g., physically violent) and nonaggressive (e.g., stealing, lying) behaviors utilizing parent management training. This approach has been demonstrated to change child classroom and at-home behaviors.

Henggeler and Sheidow (2012) studied extensively the use of Multi-Systemic Therapy (MST) with conduct-disordered youth. They have demonstrated results of reduced re-arrests and incarcerations as well as reduced recidivism rates among young sex offenders. In their review of the use of MST with conduct disordered youth, they found that the use of MST has resulted in improved family relations (Hengeller et al., 1986; Henggeler, Melton, & Smith, 1992), decreased behavior problems (Borduin et al., 1995; Hengeller et al., 1986, 1999; Letourneau et al., 2009; Ogden & Halliday-Boykins, 2004), decreased emotional problems (Hengeller et al., 1986; Ogden & Hagen, 2006), improved peer relations (Borduin, Schaeffer, & Heiblum, 2009; Henggeler et al., 1986; Henggeler et al., 1992; Ogden & Halliday-Boykins, 2004), reduced sexual offending (Bourduin et al., 2009; Borduin, Henggeler, Blaske, & Stein, 1990; Letourneau et al., 2009), reduced recidivism and criminal offending (Borduin et al., 1990; Borduin et al., 1995; Henggeler et al., 1992; Henggeler et al., 1999; Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993; Rowland et al., 2005; Schaeffer & Borduin, 2005), and decreased out-of-home placement (Henggeler et al., 1992, 1999; Ogden and Halliday-Boykins, 2004; Ogden and Hagen, 2006; Rowland et al., 2005; Schoenwald, Ward, Henggeler, & Rowland, 2000; Stambaugh et al., 2007). MST has also been used to treat adolescents with poorly controlled diabetes. Researchers have found that the use of MST has led to increased treatment adherence (Ellis et al., 2004, 2005a, 2005b, 2007, 2008; Naar-King, Ellis, Idalski, Frey, & Cunningham, 2007), and a reduced number of emergency room visits (Ellis et al., 2005b, 2008).

There has been some research done on the efficacy of Multidimensional Treatment Foster Care (Chamberlain, Saldana, Brown, & Leve, 2010), which is used to treat youth in need of out of home placement. Randomized Control Trials (RCTs) have demonstrated strong treatment results of Multidimensional Treatment Foster Care, including decreased criminal charges (Chamberlain & Reid, 1998; Leve, Chamberlain, & Reid, 2005), fewer days incarcerated (Leve et al., 2005), and decreased externalizing symptoms, depression, and psychiatric distress (Westermark, Hansson, & Olsson, 2011).

Multidimensional Family Therapy (MDFT) is a combination of family therapy, individual therapy, drug counseling, and multiple systems-oriented intervention approaches (Liddle, 2002). In two different RCTs comparing MDFT to empirically supported individual approaches, adolescents in the MDFT treatment groups demonstrated a

sustained decrease in the involvement in drugs through a 12-month follow-up (Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008; Liddle, Rowe, Dakof, Henderson, & Greenbaum, 2009).

The majority of efficacy studies involving childhood depression and anxiety have focused on family-based therapy approaches and the results of the studies have demonstrated that family-based approaches are comparable to individual approaches, and in some cases superior (Northey et al., 2003). In a study done by Diamond, Reis, Diamond, Siqueland, and Isaacs (2002), attachment-based family therapy was shown to be effective in treating adolescents experiencing major depressive disorder. In an RCT, adolescents who completed the 12-week program experienced reduced symptoms of depression and anxiety, feelings of hopelessness, and suicidal ideation, as well as a greater improvement in mother-adolescent attachment.

Family therapy research has continued into such areas as adult schizophrenia, psychosomatic symptoms, addictions, depressions, anxiety, couple distress, and sexual dysfunction. While the field has experienced conceptual and methodological problems, the outcome of well-designed studies indicates the effectiveness of family therapy.

CONCLUSION

Family therapy is the clinical application of systems theory in working therapeutically with children and adolescents. It has added to the therapist's options of looking at problems and methods of effecting change. The primary orientation is toward evaluating the relevant context in which behaviors occur and what factors within that context maintain the presenting problem(s). Interventions are designed to increase family members' ability to function in that context. Family therapists are not particularly interested in the historical etiology of problems, but rather the factors that allow the problem behaviors to continue.

Within the field of family therapy, discussion continues about the aspects of family functioning that are most salient for therapeutic focus. This chapter described three of these in terms of theory, interventions, group procedures, and educational applications. Assessment covers structure and organization of family hierarchy and boundaries, patterns of interaction, and the belief system of individual members or of the family as a whole.

There are several new directions for family therapy. Research will continue to measure outcomes and demonstrate the effectiveness of interventions. These studies will need to state more specific questions such as which theory/technique is effective with what kinds of problems on what kinds of families. Future research studies will include questions such as: When should structural interventions be applied? Are tasks given to complete within the session more effective than those given outside the session?

While family theorists may argue about the correctness of a given approach, clinical practitioners do not seem to be as concerned. In fact, there has been much more of an integration of approaches in the past few years. The overview theory described in this chapter is an example of this trend. Systems therapists are beginning to apply contextual theories in new areas. One example is the training of family medicine physicians. Family therapists have begun to work closely with these physicians in cases involving physical, behavioral, and emotional difficulties (Doherty & Baird, 1983). Another application is in the area of organizational consultation. Schools, businesses, and work teams are systems to which these principles have been applied.

Case Study

Susan, 6 years old, was referred to therapy in the spring of her first grade year because she was having significant emotional and behavioral problems. In school, she had trouble getting along with her peers, was sometimes outwardly defiant toward her teacher, and frequently had to be redirected. She complained of stomach aches and went to the school nurse several times a week. In addition, Susan had begun having tantrums at home, often during times of transition, and particularly when it was time to get ready for school.

Relevant Background Information/Family History

Susan was the younger of two girls born to Cathy, 32, and Tom, 33, who had been married for 12 years. Tom had been an independent truck driver during their entire marriage, and his schedule was often unpredictable, sometimes taking him away for days at a time. Cathy had not been employed outside the home since Susan started having health issues when she was a year old; prior to that, she had worked part time as a receptionist in an insurance company, while her cousin, who lived nearby, provided child care. Susan's older sister, Elaine, 11, was quiet, easygoing, and very helpful. Cathy had had two early miscarriages between Elaine and Susan, but her pregnancy with Susan was relatively easy.

Susan was described as a colicky baby who was difficult to soothe. She began to experience respiratory problems when she was a year old. In the following two years, she had been evaluated by a number of medical specialists and she was hospitalized several times. Finally a diagnosis of atypical asthma triggered by allergies to dust, cats, and dogs was confirmed. Both parents agreed that this was an extremely difficult time for everyone as they learned how to modify both their environment and their expectations of Susan. Her symptoms were exacerbated when she cried, so they were reluctant to set limits with her. They lived in almost constant fear their daughter would stop breathing; even at a young age, Elaine was aware of Susan's symptoms and would often alert her parents that she was having trouble breathing. Although Susan had not been sick for several years, the parents admitted to a fair degree of watchfulness due to fear of relapse. Cathy felt that she worried more than Tom, since he was often not home.

Susan had not gone to preschool or kindergarten. Cathy and Tom report that she was "moody," but they had learned how to anticipate her moods, and were able to interrupt her temper tantrums by distracting her. Cathy also admitted to giving in to her, as long as it was not "too big a deal." Cathy had been very nervous about sending Susan to school, despite Elaine's success there. Susan often complained that the teacher was "mean" to her, and she missed a lot of school. Cathy felt the teacher was only interested in making Susan obey and did not understand her sensitive temperament.

Assessment

There were two relevant interactional systems to consider in understanding what maintained (not what caused) Susan's problems; the family and school systems. After three family interviews, a conversation with Susan's family physician, and consultation with the school, an assessment was made of the (a) structure/organization of these systems, (b) patterns of interaction, and (c) the beliefs held about Susan's problems.

The family had organized itself around Susan's challenging temperament and early medical issues in a way that may have made sense at the time, but which were no longer useful. There were poorly defined boundaries within the family, particularly around Cathy and both girls. It was difficult for Cathy to know what level of responsibility Susan should be given. To the extent that Cathy did things for her, Susan sensed her mother's concern and acted in ways to justify it. In addition, in Tom's absence, Cathy often relied on Elaine for support, both emotional and concrete help with household tasks. Cathy admitted to feeling overwhelmed and exhausted, and somewhat resentful that Tom was gone so much of the time. The understandable patterns of protection that developed around Susan's illness were delaying Susan's emotional growth.

Susan's behavior was very disruptive in her first grade class. The teacher shared that she wanted children to learn responsibility, and had her classroom set up with learning stations with self-directed activities. Susan required more direction than would have been expected by a 6-year-old, and the teacher acknowledged that she often heard herself correcting Susan. Susan lacked social skills, and was sometimes destructive to other children's projects and work. "It was like having a 3-year-old in my class," she said. Susan often came home crying about her teacher being "mean." Cathy called the school to complain, and expressed a belief that the teacher should be more understanding of Susan. Therefore, Susan's teacher was reluctant to set limits with Susan, so when Susan refused to do things the teacher asked or was disruptive, she was removed from the classroom and Cathy was called to come get her. On the few occasions when Tom happened to be home, he was able to intervene, and instead of bringing Susan home, he set kind but firm limits and she was more cooperative at school. Cathy had, on occasion, even called Tom to come home early when Susan was having a particularly difficult time. Cathy, Susan, and Elaine felt that things were much easier when Tom was home.

Interventions

Using the assessment data about structure, patterns, and belief systems, the following interventions were among those implemented during the course of therapy:

1. With a release in place, the therapist contacted Susan's physician, who assured the therapist that Susan's asthma was under good control, although she did say that Susan's allergies needed continued treatment and some monitoring. The therapist encouraged the school nurse to contact Susan's family physician so that she was familiar with the treatment plan if Susan did have an asthma exacerbation.
2. The therapist encouraged Tom and Cathy to take Susan to her physician, and coached them to ask about how to keep her asthma under good control, and whether stress and upset were triggers.
3. The therapist facilitated a meeting with Susan's teacher, guidance counselor, school nurse, Tom, and Cathy. The agenda was to repair the misunderstandings between the school and the family, and to develop a unified plan for assisting Susan to succeed at home and school. The school had been unaware of Susan's early medical history, and this was shared. This helped them to understand Cathy's "overprotectiveness." They reassured Cathy and Tom that they had a plan in place to address potential medical emergencies.

   Susan's struggles were reframed as her having "missed a step" in her development rather than as evidence of willfulness and destructiveness. The guidance counselor suggested some strategies for helping Susan to have more success socially. Cathy and Tom shared some strategies they used to gain Susan's cooperation at home, such as giving her a warning prior to transitions. The teacher also shared some of her classroom management strategies such as giving children responsibility for keeping their things organized and allowing them to participate in some of the chores to maintain the classroom, such as wiping tables after snack and watering the plants. Cathy and Tom agreed to give Susan more responsibility at home.

   It was agreed that Susan be given permission to go to the reading nook in the classroom when she felt overwhelmed and needed a break, but that she would no longer be allowed to go home (unless really sick, of course). Susan was included at the end of the meeting so that she would see that all the adults were in agreement about the plan.
4. Tom and Cathy agreed to bring their family to family therapy. The focus of therapy was to restore more functional boundaries and roles among the family members. Through the use of technology, they found ways to help Tom to be "present in his absence," and he became more of a daily presence in the girls'

(and Cathy's) lives. Cathy no longer felt so alone in the parenting responsibilities, and she was able to stay steady with the plan. With some of the focus off Susan, both Tom and Cathy realized that Elaine was showing some signs of perfectionism and was having stress-related headaches. They "fired" her from taking responsibility for some of the household chores and from being the "golden girl."

Analysis

The family/school conference was an intervention designed to establish a clear hierarchy and appropriate boundaries between the adults and children in the system. Susan was included in a way that presented the message as clearly as possible. She was put in a student/child role and the discussion was in the language of teaching and learning new skills rather than control or punishment of past behavior.

Reframing was used to present an alternative reality/belief system to all involved. Susan was presented as a girl with important developmental tasks to learn rather than an emotionally disturbed or "naughty" child. This intervention served to shut the door on guilt for the parents and open the door to embrace and practice new, more competent behaviors. The structural move to increase Tom's involvement was designed to give him a more responsible role, and give Cathy a break. Tom found out earlier about any problems and dealt with them more effectively. This replaced the mother's helpless dance and may have helped to break the pattern that maintained Susan's problematic behavior.

The focus on Elaine was not used solely to take the spotlight away from Susan although that was one benefit. It also provided a different role and alternative belief system for Elaine and added a more active nurturing dimension to the relationship between her and her parents.

Results

There were dramatic and significant improvements immediately between home and school in the areas of collaboration, support, and communication between the adults. Susan's behavior at school also improved. Tom was able to negotiate his work schedule a month ahead, which made family events more predictable. He reported being happy with being more involved in a school-home program and felt successful. Cathy began looking for a part-time job, and reported feeling less stuck and overwhelmed.

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Boscolo, L., Cecchin, G., Hoffman, L., & Penn, P. (1987). *Milan systemic family therapy*. New York, NY: Basic Books.

The authors are two members of the original Milan team and two American Milan therapists. In the Introduction, the authors report the evolution of this approach. The remainder of the book is dedicated to case studies of family therapy from a Milan perspective.

Goldenberg, I., & Goldenberg, H. (1985). *Family therapy: An overview* (2nd ed.). Monterey, CA: Brooks/Cole.

This excellent overview for the uninitiated covers family systems and family dysfunction, several major theoretical perspectives, techniques of family therapy, and training. It is frequently used as an introductory text at the master's level in marriage and family therapy courses.

Gurman, A. S., & Kniskern, D. P. (1981). *Handbook of family therapy*. New York, NY: Brunner/Mazel.

This is considered one of the major texts in family therapy today. Under one cover, first-generation theorists (for the most part) in family therapy have written about their theories in a manner that allows for comparison. Also included are excellent chapters on the history of marriage and family therapy and research into this field.

Haley, J. (1987). *Problem-solving therapy* (2nd ed.). San Francisco: Jossey-Bass.

This is the second edition of a classic book in which Haley first coined the term *strategic therapy*. It is a clear exposition of the basic tenets underlying Haley's approach to family therapy, a combination of structural and strategic concepts. His chapter on conducting the initial interview is particularly good for new therapists who are desirous of a structured way to conduct a family interview. His chapter on ethical issues attempts to address charges that strategic practices are deceptive or manipulative.

Madanes, C. (1984). *Behind the one-way mirror*. San Francisco, CA: Jossey-Bass.

These well-written books have been useful additions to the scope of strategic family therapy. Madanes emphasizes planning ahead and discovering hidden metaphors in families. The majority of case examples in these books involve children and her unique pretend interventions describe ways for therapists to more gently change patterns in a family.

Micucci, J. A. (2009). *The adolescent in family therapy*. New York, NY: Guilford Press.

Anyone interested in learning systemic family therapy should read this book. It is a clearly written text, using mostly structural family therapy. One of its strengths is the plethora of case examples. It is written so that both students and experienced clinicians can relate to it and glean a deeper understanding of the unique needs of adolescents and their diverse families. Its chapters focus assessment and treatment of several of the most common mental health issues that adolescents face including: eating disorders, depression, suicide, anxiety, defiance, psychosis, and leaving home.

Minuchin, S. (1976). *Families and family therapy*. Cambridge, MA: Harvard University Press.

This seminal text in structural family therapy is an excellent place to begin reading. Minuchin clarified his theory through verbatim therapy transcripts and parallel commentary. Particularly helpful in this book is the description of family mapping, an assessment technique that allows a therapist to visually place family members or involved systems in space to design structural interventions.

Mirkin, M., & Koman, S. (Eds.). (1985). *A handbook of adolescents and family therapy*. New York, NY: Gardner Press.

The contributions to this handbook cover many topics related to adolescence. The first section of the book covers theoretical issues, while authors of the second explore settings in which therapy occurs. The last two sections of the book address issues in treatment such as

substance abuse and suicide. This book is highly recommended for professionals working with adolescents.

Papp, P. (1983). *The process of change*. New York, NY: Guilford Press.

Peggy Papp, writing from a systemic perspective, provides a very clear approach to treating families. She describes systemic hypothesizing and innovative interventions in practical terms. This is an enjoyable book to read.

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This is a wonderful introduction to looking at families from multiple feminist perspectives. The book begins with an introduction to the feminist critiques of the early family therapy models and then proceeds to cover contemporary life-cycle issues like divorce, gay and lesbian families, and parenting adolescents. The next parts of the book examine ethnic identities and family, then family power dynamics including power issues around common mental health concerns. The book concludes by taking a sociopolitical look at service delivery systems and forces that revolve around family issues like family violence.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change*. New York, NY: Norton.

Written by the early pioneers in family therapy and based on the work of Gregory Bateson and the Palo Alto project, these are the basic assumptions of one version of strategic brief therapy. Innovative interventions are presented that are consistent with these assumptions. Descriptions of how solutions can become problems and the concepts of first- and second-order change are presented.

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CHAPTER

10

Children and Adolescents with Disabilities

Implications for Interventions

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Counseling and psychotherapy with children and adolescents with disabilities has been shown to be helpful in improving mental health and functional adaptation. The purpose of the chapter is to provide an introduction to conducting counseling and psychotherapy with individuals with disabilities. The chapter is organized to provide general commentary about special considerations when working with children and adolescents with disabilities; general commentary is followed by discussion of conducting psychotherapy with five groups: (1) autism spectrum disorders, (2) learning disabilities, (3) intellectual disabilities, (4) traumatic brain injury, and (5) physical disabilities. Within each group, authors highlight unique considerations for working with children and adolescents and emphasize evidence-based therapy findings when applicable.

GENERAL CONSIDERATIONS

Although children and adolescents with disabilities vary widely across and within diagnostic groups, general heuristics are important to consider when providing psychotherapeutic services for individuals with disabilities. First, children and adolescents with disabilities will likely receive special education services. As such, counseling and psychotherapy should be coordinated with services provided within educational settings.

Second, children and adolescents with disabilities will likely interact with various professionals; therefore, counseling and psychotherapy should include consultation with other health care and educational providers.

Third, counseling and psychotherapy may involve family and caregivers and family involvement may take various forms. As discussed within the chapter, parents and caregivers experience heightened levels of parenting stress and may benefit from parent-directed intervention that focuses on coping. Parents and caregivers may also be enlisted to help with the implementation of individual counseling, such as providing support and coaching for cognitive techniques to manage distress or pain for children with physical disabilities. Parents, caregivers, and siblings may also participate in family therapy with individuals with disabilities. Various types of involvement of parents and caregivers are illustrated within the chapter.

Lastly, counseling and psychotherapy will likely require modification for use with children and adolescents with disabilities. Previous chapters in the text have outlined various therapeutic strategies for working with children and adolescents from varied frameworks. When providing counseling and psychotherapy for children and adolescents with disabilities, the psychotherapeutic process will likely require modification to benefit the client. Due to various cognitive, motor, language, attention, and adaptive limitations demonstrated by children with disabilities, the delivery of counseling and psychotherapy will need to be tailored to match an individual child's strengths and weaknesses. As such, therapy should be informed by input from various stakeholders, such as medical professionals, special educators, speech-language therapists, and occupational therapists, among others, to develop psychotherapeutic interventions that match client abilities. For example, therapeutic modifications may include (a) altering delivery of educational materials due to cognitive limitation, (b) reduced length of sessions due to fatigue, (c) use of augmentative and adaptive communication devices due to speech limitations, and (d) increased frequency of sessions due to memory consolidation problems.

AUTISM SPECTRUM DISORDERS

Effectively meeting the behavioral and mental health needs of children and youth with autism spectrum disorder (ASD) requires understanding, flexibility, and creativity. Despite the shared characteristics of impaired social communication development and repetitive patterns of behaviors and restricted interests, ASD represents one of the most heterogeneous *DSM* disorders. Although the diagnosis of ASD helps inform general areas of treatment need, it is insufficient for setting individualized therapeutic goals and selecting specific treatment approaches. Today, practitioners have several examples of empirically supported, behavior-based interventions and a growing number

incorporating cognitive-behavioral components to guide treatment (e.g., Chalfant, Rapee & Carroll, 2007; Harris & Delmolino, 2002); but the heterogeneity in ASD makes no single protocol effective for every individual. Instead, to be able to determine what works best for a specific child, the clinician must have a solid understanding of the impact of ASD on behavior and learning, the ability to interpret behavior from the child's viewpoint, the flexibility to apply trial-and-error, and originality to develop treatment materials. Because children start at different baseline levels of skill, have different treatment goals, and have individualized treatment plans, an idiographic outcome-based approach such as goal attainment scaling is necessary for measuring treatment success (Ruble, McGrew, & Toland, 2012). In this section, we describe both the differences within social communication skills and repetitive patterns of behaviors and interests and the common learning styles of individuals with ASD. Understanding the shared ways individuals with ASD experience the world helps the clinician appreciate the culture of autism (Mesibov, Shea, & Schopler, 2005); moreover, the clinician who is able to apply a conceptually sound approach for adapting interventions will have more success compared to a clinician who works within an atheoretical model (Mesibov et al., 2005; Ruble & Mathai, 2010). We then provide descriptions of empirically supported strategies that can be embedded within treatment plans to facilitate the therapeutic process. We conclude with special consideration for parents and families.

Special Issues and Social-Emotional Concerns

The heterogeneity of expressed behaviors illustrates the scope and range of characteristics associated with autism and reinforces its designation as a "spectrum disorder." Of the core impairments, social communication skills can range from aloof, passive, or active but odd (Wing, 1997); atypical social emotional cognitive understanding also varies (Celani, Battachi, & Arcidiacono, 1999), such as abilities to interpret and express nonverbal and verbal social communication, even for those with extensive verbal skills (Johnson & Myers, 2007). Restricted and repetitive patterns of behavior or interests may include recurrent motor movements such as body rocking and hand flapping, complex compulsive behaviors or preoccupations with specific cognitive themes, as well as resistance to changes in routines (Leekam et al., 2007; Mink, Mandelbaum, Tuchman, & Rapin, 2006). Although not considered a core feature, intellectual abilities vary and as many as 40% of children have intellectual disability in addition to ASD (Centers for Disease Control and Prevention, 2012).

Cognitive Theories

Three cognitive theories offer important information for appreciating the unique ways of understanding in children and youth with ASD: (1) theory of mind (TOM), (2) central

coherence (CC), and (3) executive function (EF; Volkmar, Lord, Bailey, Schultz, & Klin, 2004). Each theory is important to understand because of the links that can be made to effective interventions. The first, TOM, is the ability to understand and attribute meaning of mental states (Baron-Cohen, Tager-Flusberg, & Cohen, 2000). Difficulty understanding the source of thoughts, feelings, and behaviors of self and others creates challenges in social problem solving and social interactions. For example, a child who talks incessantly about pro wrestling will not appreciate that others may not share the same interest and be confused when classmates become avoidant. The second, CC, refers to the tendency to focus on details rather than the overall meaning or global whole (Frith & Happe, 1994). CC may help explain problems individuals with ASD have in generalizing information from one situation to another (Plaisted, 2001). For example, a youth with ASD learns the school rules and follows them faithfully but may become upset when classmates break the rules. Not being able to take into account the social context, the youth reports the rule breakers openly during class to teachers unaware of the negative impact this will have on future relationships with peers. The last theory, EF, is a general term that refers to the abilities to initiate, sustain, shift, and inhibit behavior (Denckla, 1996). EF problems can be attributed to difficulties taking in multiple types of information, making decisions quickly based on this information, and evaluating the outcomes of the situation. For example, a child with ASD who blurts out answers in class even after the teacher ignores the remarks is having difficulty identifying the problem and generating solutions.

Comorbid Issues

Treatment goals will often need to address comorbid psychiatric disorders that may include depression, anxiety, obsessive compulsive disorder, and bipolar disorder (Kim, Szatmari, Bryson, Streiner, & Wilson, 2000; Tantam, 1991). Anxiety and depression are reported as the most frequently occurring secondary conditions (Hammond & Hoffman, 2014). Research suggests that the percentage of youth with comorbid anxiety may range from 39% to 56%, and depression may range from 10% to 44% (Mattila et al., 2010; Mazefsky, Conner, & Oswald, 2010). Thus, it is essential that clinicians be able to address the emotional issues often associated with ASD.

Maladaptive behaviors may also be a concern. Although not part of the diagnostic criteria for ASD, maladaptive behaviors may be associated with the underlying impairments of social communication, and restricted or repetitive behaviors (Dominick, Davis, Lainhart, Tager-Flusberg, & Folstein, 2007). Problematic behaviors serve various functions such as asserting control over one's environment (Howlin, 1998) or communicating pain, dislike, frustrations, and refusals. To address such issues, a functional behavioral assessment (FBA) that includes positive behavior supports is

necessary (Nounopolous, Mathai, & Ruble, 2009). FBA is used to understand the purpose of a behavior, which, in turn, guides intervention (Cooper, Heron, & Heward, 2007). Several meta-analytic studies have substantiated the efficacy of FBA in reducing problem behaviors for individuals with ASD (e.g., Campbell, 2003).

Therapeutic Approaches

Selecting goals for treatment is best done using a multimethod, multisource approach, including parent and teacher interviews and direct child assessment. Treatment assessments may focus on the core social communication impairments associated with ASD, such as social skills (Stone et al., 2010) or comorbid issues of anxiety, depression, or maladaptive behaviors. For preschool and young children, effective early intervention programs typically target core symptoms, are theory-driven, involve 20 hours or more of intervention, and a program for transitions (see Lord & McGee, 2001). For older children and youth, treatment plans may also include issues associated with anxiety, mood, or behavior disorders. A functional behavioral assessment approach should be considered within all treatment planning, including internalizing disorders so that the communicative function of underlying problematic behaviors is identified (Lang, Mahoney, Zein, Delaune, & Amidon, 2011).

After careful assessment of needs from multiple sources, successful implementation of a treatment plan involves structuring the therapeutic relationship. For those with ASD, this requires a more directive approach (Anderson & Morris, 2006) whereby expectations of the therapy process and goals are clearly established with the parent and child, when possible. Often, children and youth with ASD have significant organizational problems and difficulties following through with assignments or homework. A lack of compliance is not necessarily associated with resistance. Explicit examples and assistance with scheduling is necessary and often teaching problem solving can be used to identify solutions to disorganization. For example, handouts can be used to visually guide the process of social problem solving (e.g., Bloomquist, 2005). Active and attentive engagement during the session is facilitated by visual schedules and self-monitoring/regulation strategies (Laurent & Rubin, 2004). A goal is established at the beginning of the session and, if needed, a reward is also identified for goal accomplishment (e.g., answering questions; completing homework). Due to the difficulty individuals with ASD have with generating solutions to problems, they often have difficulty conceptualizing the benefit of therapy across many areas (e.g., building relationships, dealing with frustration). Identifying the connections between therapy goals and long-term outcomes is necessary. For example, for an adolescent who is not completing school work, explicit discussion of the importance that homework has on grades, graduation, and a future goal of being a computer programmer can be helpful.

Treatment of Core Symptoms

After treatment evaluation and goal selection, it is necessary to establish specific strategies designed for increasing social cognitive understanding, prosocial behaviors, and other skills identified by the assessment. Due to combined effects of disordered development of TOM, EF, and WCC, therapeutic techniques must be adapted, individualized, and tailored to each individual with ASD (Elder, Caterino, Chao, Shaknai, & DeSimone, 2006). Research has shown that cognitive behavioral treatment can be specifically tailored to include skills training and social coaching for individuals with ASD (Lang et al., 2011). The promotion of skills teaching and incorporation of cognitive-based strategies allows for not only the development of new skills but also an understanding of the importance of specific skills. Described next is a four-step procedure for direct instruction. Examples of evidence-based strategies of visual supports, social stories, video self-modeling, self-management, and relaxation training are provided.

In our work, we have found that treatment plans that include a general four-step procedure are effective. The steps include: (1) introducing the skill and describing why it is important; (2) showing what the skill looks like; (3) role-playing the skill; and (4) practicing the skill at home (Ruble, Willis, & Crabtree, 2008). A Social Story™ (Gray, 2000) is used to introduce the importance of the skill from another's perspective. Social Stories™ provide written information that describes situations, others' perspectives about the situation, skills, and responses. Next, a sorting activity that breaks down the skill into its component parts (i.e., a task analysis) or depicts the correct vs. incorrect way to perform the skill is implemented; the use of picture cards (e.g., pictures from magazines, hand drawings on 3 × 5 cards) helps individuals develop a concrete depiction of the positive skill being taught (Baker, 2001). Third, role-plays and feedback are standard techniques (Barnhill, Cook, Tebbenkamp, & Myles, 2002) for the specific skill and, when possible, based on issues described by the individual or by parents. Fourth, because of the difficulty generalizing information from a clinical context to home, school, and community settings, treatment plans should include activities that address problems with generalization (Elder et al., 2006; Reaven & Hepburn, 2003) such as homework. If parents, caregivers, or significant others are not part of the treatment session, either through observation or as part of family therapy, it is necessary that as much information as possible be shared with them, including extra materials for home use.

In each of the four steps, visual supports—a common element of effective interventions—are incorporated. Visually depicted information allows for in-depth definitions or task analysis of skills (e.g., drawings to depict social situations) that enhance concept learning of abstract concepts. Visual cuing also serves as a prompt to

help the person organize thoughts and initiate interactions. Social stories and comic strip conversations (Gray, 2000) are strategies used to help explain perspectives of self and others. Cognitive scripts assist in teaching the person to initiate and maintain conversations independently while video self-modeling (Buggey, 2005) teaches positive behaviors and reduces unwanted behaviors by allowing persons to view themselves in situations where they are performing at a more advanced level than they typically function. Power cards (Keeling, Myles, Gagnon, & Simpson, 2003) incorporate special interests of the person with ASD as part of the teaching and reinforcement of academic, behavior, and social skills. The common element of all these strategies is that they take into account the need for concrete information that is not abstract and is based on visual learning.

Other therapeutic goals often embedded within therapy sessions are self-management and relaxation training. Self-management procedures are behavioral techniques that require individuals to actively monitor their own actions and appropriately provide reinforcement in response to these behaviors (Bregman et al., 2005). Koegel, Frea, Surratt, Schopler, and Mesibov (1994) suggested that by teaching individuals with ASD how to self-monitor, new complex skills are developed that serve to decrease problematic behavior. Self-management techniques have been shown to reduce a variety of maladaptive behaviors such as tantrums, aggression, and vocal outbursts (Krantz, MacDuff & McClannahan, 1993; Mancina, Tankersley, Kamps, Kravits, & Parrett, 2000).

Relaxation training and cognitive picture rehearsal are other methods for reducing negative behaviors. Progressive relaxation procedures that include systematic tightening and relaxing of muscles and breathing techniques have received some support in the literature to reduce problematic behavior (Mullins & Christian, 2001). Cognitive picture rehearsal is a technique that has shown promise in reducing maladaptive behaviors among low-functioning individuals with autism (Groden & LeVasseur, 1995). The picture rehearsal approach utilizes drawings and/or pictures with short narratives in sequence to address a specific concern displayed by an individual. The sequence typically involves the antecedents to a problem situation, the desired or expected behavior, a coping technique, and a potential reinforcer (Baker, 2001).

With the addition of these components and the emphasis on building problem-solving skills, the reduction of undesired and promotion of preferred behavior can be directly addressed. Nevertheless, although a plethora of research exists on behavior management among individuals with ASD, "no single intervention has been shown to deal effectively with problem behaviors for all children with autism" (Lord & McGee, 2001, p. 118). Further, interventions that fail to recognize significant challenges such as anxiety disorders, a common comorbidity among individuals with ASD (Kim et al., 2000), may overlook an essential piece to positive long-term posttreatment outcomes.

Therefore, emphasis should be placed on the individualization of treatment and the involvement of cognitive strategies.

Treatment of Anxiety and Mood Disorders

Treatment research shows that individuals with ASD can benefit from psychosocial interventions, such as cognitive behavioral strategies, to ameliorate anxiety, depression, self-injurious behavior, and obsessive compulsive disorder (Anderson & Morris, 2006; Attwood, 2007; Reaven & Hepburn, 2003; Sofronoff, Attwood, & Hinton, 2005). The diagnosis of ASD cannot be ignored as part of treatment, however, as research also suggests that problems of anxiety or depression may be influenced by the social perceptions and behaviors of individuals with ASD (Meyer, Mundy, Van Hecke, & Durocher, 2006). Another unique aspect that must be emphasized when applying cognitive behavior therapy to individuals with ASD is that more time often needs to be spent on emotion education and learning the relationships between emotions, thoughts, and behaviors. Although not specific to ASD, Bloomquist (2005) has several visually aided resources on emotion education and helpful and unhelpful thoughts. Anderson and Morris (2006) provide a detailed overview of the strategies to adapt the components of cognitive behavioral therapy for individuals with ASD. Modifications include use of visually based systems for establishing baseline symptoms and goal monitoring, such as utilizing a visual "emotion thermometer."

Family and Parent Issues

Many families deal with issues that are common to families with a child with a chronic medical or psychiatric disorder, but research suggests that the experiences are not entirely similar. Parents of children with ASD report greater stress compared to parents of children with other special health care needs (Estes et al., 2013). Issues may involve sadness and grief, fatigue and lack of patience, guilt, confusion understanding the symptoms, sibling embarrassment, acceptance of ASD, and problems accessing services (Ruble, Mathai, Tanguay, & Josephson, 2008). Stress is especially pronounced for caregivers of children with problem behavior (Estes et al., 2013).

Family and parent issues may be addressed through family interventions that include psychoeducation and behavior management training (Estes et al., 2013), as well as home services and the integration of family therapy with psychotherapy (Ruble & McGrew, 2007). The psychoeducational model is the most common model of family intervention in ASD. In this model, parents are supported in dealing with the disorder and given information on treatment options. Stress in the family is often a response to managing difficult symptoms. Yet, a careful family evaluation may identify issues of family distress and functioning that leads to a worsening of child symptoms. Further assessment should include parents' knowledge of developmental norms,

parental alliance and support, success outside the parenting world, and stability of the other children.

INTELLECTUAL DISABILITY

Children and adolescents with intellectual disabilities (ID) encompass a heterogeneous group of individuals with various etiologies and courses. The American Psychiatric Association (APA, 2013) recently noted that intellectual disabilities impact about 1% of the population; males are more commonly diagnosed with both mild and severe ID (1.6 to 1; 1.2 to 1, respectively). In many ways, there has been an increase in general understanding about ID among practitioners and to some extent among laypersons, and comprehensive services in the schools and community are more common. Further, there has also been an important change in the nomenclature, where the terminology has shifted to a person first language (i.e., children with ID) and from the antiquated term *mental retardation* (MR) to ID. For the purposes of this chapter, prior literature using the outdated term of MR will be replaced with the more appropriate usage of ID.

Identification

Clinicians benefit from having a good basic knowledge and understanding of general assessment practices and diagnosis for ID. The recently revised *Diagnostic and Statistical Manual*, fifth edition (*DSM-5*; APA, 2013), provides guidelines for identification of ID including: (a) deficits in intellectual functions, (b) deficits in adaptive functioning … [that] limit functioning in one or more activities of daily life, (c) onset of deficits during the developmental period (p. 33). An additional aspect of the diagnosis that facilitates better programming for individuals with ID are specifiers of severity (i.e., mild, moderate, and severe); these specifiers are based on adaptive functioning and level of support required for the individual.

In order for children and adolescents to receive school-based services, they must qualify under the Individual Disabilities Education Act (IDEA; U.S. Department of Education, 2004). Every state interprets the federal law into their respective criteria of ID, yet the general description from the regulations details the following: (a) significantly subaverage general intellectual functioning, (b) deficits in adaptive behavior, (c) manifests during the developmental period, and (d) adverse effects on educational performance (U.S. Department of Education, 2004). Many states provide a similar specifier or general level of functioning, for example Mild Mental Disability and Functional Mental Disability (Kentucky Department of Education, 2008); the distinction is determined by cognitive and adaptive scores and can subsequently be used to determine instructional supports and personnel. Regardless, individual characteristics of the student with an ID should help guide the planning committee on teaching methods.

Special Issues and Social-Emotional Concerns

In addition to the need for direct instruction in the areas of academics and adaptive functioning, general well-being of children and adolescents with ID should be considered. Positive mental health allows individuals to perform at their individual best; thus, clinicians should be cognizant of potential comorbid psychopathology. Reports of such comorbidity have greatly varied within this population. In a review of nine published studies, comorbid conditions in ID were estimated to occur in 30% to 50% of children and adolescents with ID (Einfeld, Ellis, & Emerson, 2011). Various methodological and sampling differences were cited by Einfeld et al. (2011) to account for differences that existed. The rates of externalizing disorders and internalizing disorders were fairly similar in a recent review by Dekker and Koot (2003), with disruptive disorders reported at a rate of 25.1% and mood/anxiety disorders reported at 26.3%. In sum, the presence of comorbid conditions indicates the need for individualized treatment.

Additionally, risk factors in development of psychopathology warrant examination. Koskentausta, Iivanainen, and Almgvist (2007) indicated there are conflicting reports in the ID population, for example, if more impaired level of cognition relates to more risk of psychiatric conditions. However, Koskentausta et al. (2007) found the risk of developing psychopathology is increased under the following conditions: (a) moderate (rather than severe) ID, (b) limitations in adaptive behavior, (c) poor socialization, (d) living with one biological parent, and (e) low socioeconomic status. Several of these risk factors are congruent to those found in typical populations. Einfeld and Emerson (2008) reported that individuals with mild ID engaged in more antisocial or disruptive behaviors, while those individuals with moderate or severe behaviors experienced more problems with social relations. Similar to non-ID populations, clinicians benefit from knowledge of risk factors for developing psychopathology in individuals with ID.

Given language, cognitive, and social characteristics, clinicians should inquire about assessment of comorbid conditions for ID. The American Academy of Child and Adolescent Psychiatry (AACAP, 1999) reported that assessment of comorbid conditions should involve the same approach as for other individuals, with some slight modification due to cognitive and communication deficits. For example, a depression self-report scale, such as the *Reynolds Adolescent Depression Scale*, second edition (RADS-2; Reynolds, 2002), could be a tool used by the clinician; however, the adolescent with ID might need to be interviewed regarding endorsed items to ensure they understood the terminology and phrasing. Further, a child with ID might not have the introspection or expressive skills to articulate specific feelings of anxiety or depression. Therefore, multi-method, multisource, and individualized approaches are recommended for a better understanding of previous and current functioning to determine presence of comorbid, especially internalizing, conditions. Although not a focus of the chapter, accurate assessment of

potential comorbid conditions is recommended for adequate treatment planning and support systems.

Therapeutic Approaches

Given the manifestation of comorbid conditions, it is relevant for clinicians to have a thorough understanding of available and appropriate therapies for individuals with ID. As with assessment processes, the AACAP (1999) recommended that treatment principles for individuals with ID should be the same as for other individuals receiving therapy, with some modifications provided based on individual characteristics and communication. However, modifications to psychotherapy processes or manualized treatments may create problems with fidelity of these interventions.

Furthermore, from a more practical standpoint, clinicians might be uncomfortable in working with individuals with disabilities from a therapeutic standpoint, especially a group as heterogeneous as ID. The thought might also exist that these individuals are so distinct from typical individuals that services could not be implemented effectively. Limited knowledge or comfort levels should not prevent individuals with ID from receiving psychotherapy or other appropriate services, or that common best practices are negated because of the identified population (e.g., not coordinating treatment plans). McCarthy and Boyd (2002) reported that many individuals with ID in the United Kingdom become caught between service providers, thus not receiving congruent service delivery. Moreover, the application of treatment approaches might seem irrelevant to clinicians if the child has an ID, as clinicians may interpret ID as the root of the problem and believe that no additional supports are warranted. Einfeld and Emerson (2008) stated that "mental health professionals have tended to view emotional and behavioral disturbances in the presence of ID as a 'behavioral' manifestation rather than manifestation of ID. At the same time, disability advocates have been keen to distance ID from the perceived stigma and overly medicalized concept of mental illness." (p. 828). Both of these factors affect how children and adolescents are serviced in schools and in the community.

Matson, Terlonge, and Minshawi (2008) indicated that the bulk of intervention literature for ID has been conducted on amelioration of challenging behaviors, noncompliance, and somewhat on social skills. This also brings to light a relevant aspect of this discussion; how psychotherapy is defined for this population. Prout and Browning (2011) noted in their review of the literature that the Meltzoff and Kornreich (1970) definition has been used by many researchers and includes the utilization of face-to-face implementation of psychological principles with the intent to modify part of feelings, behaviors, values, or attitudes through the intervention. Thus, behavior modification techniques and more skill-based treatments such as shaping and task analysis may be included in the definition of psychotherapy.

In their synthesis, Prout and Browning (2011) reported that psychotherapy, broadly defined as above, is thought to be generally effective for individuals with ID. However, there were several issues with the existing literature that needed to be addressed. Prout and Browning (2011) noted the following: (a) a paucity of randomized control trials exist, (b) there is an increased need for manualized treatments, and (c) adaptations made to interventions need to be more clear and defined. Finally, research in the area of psychotherapy with ID has focused on adults; there is a need for more focused research with children and adolescents. While we await additional research, the following provides a summary of some treatments that have been found useful.

Parent Training

For younger children and those individuals with more severe ID, parent training has been shown to provide additional support for the child and family. Bagner and Eyberg (2007) studied the utilization of Parent-Child Interaction Therapy (PCIT) with young children (ages 3 to 6) having ID and comorbid oppositional defiant disorder (ODD) diagnoses. PCIT has been reported to be an efficacious training program for parents of children with severe behaviors. Bagner and Eyberg (2007) examined the use of PCIT, without modification to the program, via RCT. Results revealed initial support of PCIT with young children having ID and comorbid ODD, with disruptive behaviors decreased and mothers experiencing more positive interactions with their children. Due to the aforementioned issues of limited RCT in this population, along with the questions of adaptations and modifications, the Bagner and Eyberg (2007) research shows initial promise for parents and their ability to facilitate behavioral changes for their young children with ID.

Cognitive-Behavior Therapy

Cognitive-behavior therapy has been reported as an effective treatment for a wide range of individuals (Bruce, Collins, Langdon, Powlitch, & Reynolds, 2010), yet it has been debated in the literature as a treatment for individuals with ID due to concerns regarding the cognitive aspects of therapy (e.g., Hurley, 2005; King, 2005; Sturmey, 2005). One reason for the question is the limited scientific evidence on the benefit of such treatment; this continues to be the case in children and adolescents with ID. Yet, Bruce et al. (2011) conducted a RCT for adults with ID, specifically examining how the participants were able in a single training session to link thoughts, feelings, and behaviors. Bruce et al. (2010) found that individuals with ID successfully participated in cognitive mediation, or linking feelings to thoughts, a skill considered a prerequisite to successful CBT. However, in the first training session, the adults were unable to make the connection with their behaviors (Bruce et al., 2011). Clearly more research is needed on the use of CBT with a younger population. Regardless, King (2005) noted "practice-based evidence does

suggest that psychotherapeutic support … can be life enhancing." (p. 449), and given CBT's strong support for internalizing symptoms in particular, it should be considered for those with ID.

Behavioral Interventions

Behavioral interventions drew much attention and subsequent debate following Sturmey's (2005) conclusions that behavioral interventions were superior to other psychotherapeutic approaches for individuals with ID, regardless of the clinical concern. Hurley (2005) responded that both behavioral interventions and psychotherapy require further study for use with individuals with ID. Regardless, as a clinician, a main goal is to prioritize and effectively treat individuals based on their symptoms. It would appear that the assessment process would ultimately guide clinicians in selecting relevant treatment rather than selecting a treatment prior to working with the individual.

As noted by Matson et al. (2008), behavior interventions have been a major focus in the comorbidity research on ID. However, given the intensity and potential for harm that some disruptive behaviors contain, it is helpful for clinicians to have knowledge of types of interventions that have been utilized. Feldman, Atkinson, Foti-Gervais, and Condillac (2004) reported a variety of treatments including behavioral, including functional assessment techniques, crisis intervention, and counseling which can be implemented to decrease disruptive behaviors. The Feldman et al. (2004) review included children, adolescents, and adults, and the authors found that informal behavior interventions were the most often implemented, with informal counseling being the least implemented treatment. Many of the behavior interventions reviewed were intrusive, including medication and restraint. Beail (2005) noted that aversive interventions have not been found to be more effective than non-aversive treatments; therefore, clinicians should consider alternatives in their program planning. For a more thorough review of specific behavior interventions, readers can refer to Matson et al. (2008).

Phobia Treatments

Individuals with ID are at an increased risk for anxiety disorders; Dekker and Koot (2003) found in their large sample of individuals ages 7 to 20 that 21.9% met criteria for anxiety disorders, the largest of which was specific phobia at 17.5%. Literature on phobic avoidance was investigated by Jennett and Hagopian (2008) using defined criteria for empirical treatments in children, adolescents, and adults with ID. From the 13 reviewed studies, Jennett and Hagopian (2008) found that behavior treatments involving exposure and reinforcement were well established. CBT was less supported for treating phobic avoidance within the population. Additional research with children and adolescents should strengthen the understanding of effective treatments for the

elevated number of individuals with potential phobias. However, for the time being, clinicians can consider, as appropriate, implementing structured behavioral components in treating phobic behaviors.

Solution-Focused Brief Therapy (SFBT)

There has been recent interest in use of SFBT with individuals with mild ID. Roeden, Maaskant, Bannink, and Curfs (2011) noted that the philosophy and focus of SFBT, empowerment and skill development versus deficits, could serve those with ID well (see Roeden et al., 2011 for more detailed description of SFBT). Although Roeden et al. (2011) focused treatment on adults with ID, the initial results were promising in goal attainment and improvement of individualized functioning. Individuals with more severe ID may have difficulty participating in traditional "talk"-based counseling; however, Lloyd and Dallos (2008) investigated the use of SFBT with mothers of children with significant ID. Lloyd and Dallos (2008) found SFBT to be a useful tool in supporting families, although some modifications were necessary (e.g., the "miracle question" was reported not to be helpful). As indicated by Prout and Browning (2011), any type of modification made to the treatment process for individuals with ID should be well defined so that the modifications may be replicated. Clinicians should document changes made to treatment protocols, for the individual and for future practice.

Psychopharmacology

Although clinicians reading this chapter are more than likely not those who will be distributing medication, because of the high level of psychopharmaceutical interventions potentially provided to children and adolescents with ID, it is important to note a few important points. The AACAP (1999) reported that medication effects "generally are not different from those expected in the absence of [ID]" (p. 1610). However, the AACAP (1999) reported several commonly occurring problems with psychopharmacology: (a) lack of informed consent; (b) not integrating medication into a comprehensive treatment plan; (c) lack of monitoring for side effects, especially for those who are nonverbal; and (d) not matching medication with comorbid diagnosis of record. Thus, clinicians involved in the beneficial "wraparound" or collaborative interdisciplinary approaches could assist in monitoring and collaborating with those overseeing medication management, for example, in structuring completion of medication monitoring forms across service providers and family.

Progress Monitoring

Regardless of the therapy approach chosen, clinicians should be assessing the effectiveness of their implemented intervention. The AACAP (1999) reported that those working with the individual with ID might have different interpretations of what is effective

and what is not effective. Therefore, in order to monitor progress in psychotherapy, "discrete treatment goals should be agreed upon by the clinician, individual, and caregivers, as well as a target or 'index' symptoms" (AACAP, 1999, p. 1610). Progress monitoring of ongoing therapy is difficult without counseling goals that are measurable and individualized. Generalization also should be considered for this population. Individuals with ID might struggle to transfer skills learned in therapy to other settings, such as social skills. Clinicians working in the schools or in collaboration with the schools will find that frequent data collection related to goal attainment will facilitate communication with the family and meaningfulness of treatment. Clinicians also will want to include the individual with ID as much as is appropriate and possible in goal planning and monitoring of those goals; for example, the adolescent might graph the frequency of their appropriate peer interactions during a lunch period, as monitored by a teacher assistant. Visually representing progress toward a goal can make therapy and the therapeutic progress more meaningful for individuals with ID. Additionally, graphing progress could increase self-efficacy and self-advocacy.

Summary for Individuals with Intellectual Disability

Children and adolescents with ID deserve comprehensive treatment that is individualized and based on their unique abilities. In addition to the typically recognized instructional needs in academic and adaptive skills is that of mental health supports. Although rates vary, comorbid psychopathology appears to affect a good portion of individuals with ID. Research has focused on behavioral issues and treatment over social and mental health. In fact, disagreement about the nature of psychotherapy, its association with ID and mental illness, and overgeneralized attribution of behavior being part of ID, have all served to confound the ultimate goal of effective treatment. However, we conclude and recommend the following: (a) individuals with ID are more likely than the general population to experience psychopathology, (b) assessment should include tools to further investigate such comorbidity, and (c) upon identification, clinicians should include formal, goal directed treatment plans to address individual profiles of children and adolescents with ID.

LEARNING DISABILITY

Learning disabilities (LD) similarly encompasses a heterogeneous group of children and adolescents. At the core of the disability are struggles with components of academic processing, across reading, math, and/or writing domains. The APA (2013) reported that across the academic areas, the prevalence of LD is 5% to 15% for children from different languages and cultures. Moreover, LD is found to occur more in males than in females, between 2:1 and 3:1 (APA, 2013). Skull and Winkler (2011) reported national

data from 2009 to 2010, which indicated that 2.43 million children or 4.9% of the student body meet special education criteria for LD. Of those serviced in special education, LD comprises the largest proportion of children, at 37.5% (Skull & Winkler, 2011). Thus, clinicians in schools and private practice will more than likely work with children and adolescents with LD.

Identification

The revised *DSM-5* (APA, 2013) outlined criteria for Learning Disorder, noting it as a neurodevelopmental disorder manifesting in difficulty acquiring academic skills, not due to intellectual disability, in the areas of reading, written expression, and mathematics. The terms *dyscalculia* and *dysgraphia* are not being recommended now, and instead the broader term of *learning disorder* is used (APA, 2013). In the schools, there has been no more controversial area of assessment and placement than that of specific learning disabilities (SLD). SLD has garnered much attention in the literature and in practice, related around the philosophy of identifying these individuals; specifically whether to use the IQ/achievement discrepancy model, a Response to Intervention (RTI) model, or other models (e.g., cognitive processing). The mandate from the federal law (IDEA, U.S. Department of Education, 2004) has allowed individual states to determine their methodology of LD identification, resulting in great variation depending on residence (Berkeley, Bender, Peaster, & Saunders, 2009). IDEA (U.S. Department of Education, 2004) has set forth eight areas for SLD (e.g., basic reading, math calculation, written expression, oral expression), where a student who is not meeting grade level expectations or responding to interventions implemented in one of the outlined areas could potentially qualify. Those who are interested in learning more about the assessment process of SLD in the schools should refer to Lichtenstein (2008).

Special Issues and Social-Emotional Concerns

The AACAP (1998) reported that individuals with LD and language disorders experience elevated rates of comorbid psychiatric syndromes. DuPaul, Gormley, and Laracy (2013) reported that LD and ADHD exist at a higher rate than even previously thought, up to 45.1%, with the inclusion of writing disorders. McNamara, Vervaeke, and Willoughby (2008) found that adolescents with LD and comorbid LD/ADHD were more likely than peers without LD to engage in risky behaviors (e.g., use marijuana; engage in acts of minor delinquency). Another area that has been frequently associated with LD is depression. In a meta-analytic review, Nelson and Harwood (2011) found depressive symptoms in students with LD to occur significantly more than in students with non-LD ($d = .75$). Further, even without diagnosed comorbid conditions, individuals with LD may encounter other problems, such as social skill deficits and low self-esteem (AACAP, 1998; Kavale & Mostert, 2004). In fact, Kavale and Forness

(1995) reported that up to 75% of children with SLD had deficits in social skills as compared to peers without an SLD.

Therapeutic Approaches

Given the higher reported levels of comorbid problems for individuals with LD, clinicians should consider an array of treatments. Leichtentritt and Shechtman (2010) reported that challenges encountered by those with SLD go beyond skill deficits, which necessitate a broader "spectrum of intervention and a focus on growth and empowerment." (p. 169). Yet, the question remains: What characteristics are unique to individuals with LD that could influence benefits of therapy? At its core, as aforementioned, LD relates to difficulty processing components of academic materials (e.g., difficulty with phonemic awareness, difficulty with abstract math reasoning). There have been some questions about cognitive processing for children and adolescents with LD, but not investigated to the same extent as individuals with ID, such that modifications have been systematically studied in treatment approaches. The AACAP (1998) reported that psychotherapy with individuals with LD should be tailored to individual needs, for example, if the child found aspects of language challenging, nonverbal approaches such as games, activities, and computers might result in more participation. Another characteristic that might impact therapy is metacognition, which is an area of difficulty for many individuals with LD. Difficulty with metacognitive processes may negatively impact the ability of the child with LD to accurately report emotions during psychotherapy.

In many ways, outside of the school setting, a layperson might not be able to distinguish between a child with LD versus a child without LD. However, often children and adolescents, as a result of their LD, face additional challenges that warrant a combined approach to educational services and psychotherapeutic intervention. For example, children with LD often experience negative attitudes from peers, teachers, and other adults, as well as feelings of isolation (Lambie & Milsom, 2010). Although there are some varying hypotheses on why difficulties in social and emotional adjustment are often experienced by those with LD, negative school experiences might occur and could inform aspects of treatment.

Another consideration of treatment is when externalizing behaviors are exhibited by children with LD. Lambie and Milsom (2010) identify the "age-old issue" of whether children exhibit externalizing problems due to a preference to look "bad" over "dumb." Students with LD might exhibit comorbid behavior problems as a result of academic deficits. Thus, therapeutic approaches need to investigate the function of behavioral difficulties when intervening in both academic and behavioral domains. Lastly, although fidelity of manualized programs is preferred, if treating an individual with a reading disability, modifications to materials might be necessary to address difficulties with reading, understanding vocabulary, or comprehending questions. Similarly, when conducting

CBT with a student with a writing LD and depression, the clinician should consider slight modifications. For example, instead of having the adolescent complete homework recording negative thoughts on paper, an alternate method might be use of a tape recorder.

Martinez and Semrud-Clikeman (2004) compared adolescents with multiple LD (e.g., reading LD and math LD) to those with a single LD and typical achieving peers. In contrast to expectations, Martinez and Semrud-Clikeman (2004) found no differences between the emotional adjustment of individuals with one or more LD; however, both groups experienced poorer adjustment and more emotional symptoms when compared to the matched group. McNamara et al. (2008) reported psychosocial components, such as engagement in school and extracurricular activities and feelings of well-being, served as protective factors for students with LD. Protective factors can serve to enhance outcomes for children with LD, potentially preventing development of psychopathology.

Group Counseling

The unique learning profile and potential comorbid social and emotional problems of children and adolescents with LD might make clinicians question the utility of group counseling. Can individuals with LD participate and interact in such a group setting? Leichtentritt and Shechtman (2010) reviewed evidence and concluded that group counseling has been shown to improve social and emotional functioning in this population. Leichtentritt and Shechtman (2010) also studied a large sample of children ages 10 to 18 with LD compared to non-LD students, investigating outcomes after group counseling. Specific techniques utilized in the groups were supportive-expressive, involving a mixture of cognitive and behavioral techniques with modifications for the age range (e.g., bibliotherapy, therapeutic gains). Despite differences in academic achievement, the LD and non-LD students demonstrated similar social and emotional gains with decreases in anxiety and aggression. Mishna, Muskat, and Wiener (2010) also investigated group counseling for middle school students with LD, piloting a manualized treatment approach based on self-psychology and interpersonal group treatment. The intervention was implemented directly in the schools. Mishna et al. (2010) found support for the group therapy from parent and student interviews. Additional research with RCTs would provide more evidence for this approach; however, initial results suggest that clinicians may successfully utilize group therapy to target social and emotional concerns for individuals with LD.

Solution-Focused Brief Therapy

Franklin, Biever, Moore, Clemons, and Scamardo (2001) investigated use of SBFT with young adolescents (ages 10 to 13) with LD. Many of the participants were diagnosed with comorbid conditions, such as ADHD and anxiety disorders. Five of seven students

experienced significant improvement in their externalizing or internalizing behaviors. Franklin et al. (2001) found the flexibility of SBFT appropriate and helpful for the LD population. Further, the action-oriented nature of SBFT appears to provide the individual with LD an outlet to focus on goals to accomplish, rather than skill deficits faced in academic settings. Although additional research is clearly needed regarding SFBT, due to the nature of the approach, it should be considered as an option for children and adolescents with LD.

Social Skills Training

Social skill deficits have been well documented in individuals with LD. Yet, the effectiveness of social skills training has been questioned for various populations. One such reason is targeted skills have, at times, failed to generalize outside of the training session. For example, a student may learn how to appropriately take turns in a small group or with an adult, but may not take turns appropriately with peers on the playground or in the gym. Regardless, Kavale and Mostert (2004) indicated that social skills training has become a widely adopted intervention for children and adolescents with LD. However, in a meta-analysis, Kavale and Mostert (2004) reported that social skills interventions for this population had limited impact on social functioning. The review indicated that additional research was needed, specifically regarding the length of intervention, use of specific social skill programs, and in-group differences (Kavale & Mostert, 2004). At this time, authors recommend that clinicians consider implementing social skills training, if indicated, but do so with clear planning for generalization and ongoing monitoring of effectiveness.

Parent Training

Unfortunately, students with LD may be viewed as "lazy" or "indifferent," which can impact academic and social functioning. Therefore, parent, and sometimes teacher, training and consultation might be warranted. Specific education on the nature of LD, how LD manifests, and unique individual characteristics should be emphasized, when necessary. The AACAP (1998) noted that the clinician might work with the family to develop both a supportive home environment and a consistent home to school program of reinforcement. Encouragement and consistency may ultimately provide a protective factor from more negative school and peer experiences (e.g., Mishna et al., 2010). Additionally, clinicians in the private sector should be aware of state education policies on LD to help determine the extent and nature of school-based services appropriate for children served.

Other Therapies

In reviewing the literature on LD, some therapies have been reported for children and adolescents. CBT has begun to emerge as a therapeutic technique for individuals with

LD (Shechtman & Pastor, 2005). CBT has been shown to be effective for treating anxiety and depressive symptoms for children and adolescents (Compton et al., 2004); thus, CBT should be considered as a psychotherapeutic technique for individuals with LD given appropriate developmental or cognitive modifications due to academic or processing deficits. Shechtman and Pastor (2005) also found initial support for humanistic psychotherapy, modified for adolescents with LD. The authors noted that more research was needed to document the potential benefits of humanistic psychotherapy, as it was found to be more effective than CBT within their sample (Shechtman & Pastor, 2005). Mindfulness training, which incorporates components of CBT, has also received initial support for adolescents with LD and comorbid ADHD (Haydicky, Wiener, Badali, Milligan, & Ducharme, 2012).

Progress Monitoring

Tiered interventions, a component of RTI, might also be considered for individuals with SLD and comorbid conditions. Within the schools, students with LD will often need to be pulled out of regular education classrooms for intensive, direct academic instruction. Therefore, clinicians in the schools might consider implementing interventions in the classroom or in small group format. For example, a school psychologist could implement a whole class social skills program weekly (e.g., Second Step; Committee for Children, 2004) or target a small group with anxiety symptoms after school (e.g., Coping Cat; Kendall & Hedtke, 2006). Additionally, group, rather than individual therapy, may be considered to provide opportunities for generalization and to practice social skills required for group interactions.

As mentioned with individuals with ID, students with LD benefit from development of concrete therapeutic goals with their input. Further, to ensure that the treatment selected is beneficial, ongoing progress monitoring of goals should be carried out. Depending on the nature of the LD, clinicians should involve students in the monitoring process. As noted earlier, therapy should be a time where academics are not the focus, and utilizing individual strengths is strongly recommended to support therapeutic techniques and goals. Clinicians should also work in conjunction with parents, especially for social skill development. Incorporating parent involvement will help facilitate better generalization beyond group sessions. Overall, ongoing monitoring and collaborative methods will be beneficial for psychotherapy for individuals with LD.

Summary for Individuals with Learning Disabilities

Children and adolescents with LD often experience challenges beyond their specific academic deficits, including low self-esteem, difficulties with peer interactions, and potential comorbid conditions such as depression, anxiety, and ADHD. Therefore, clinicians working with children and adolescents with LD should assess for comorbid concerns,

and consequently consider the implementation of therapeutic techniques extending beyond academic skill building. Continued research comparing various therapies will help clinicians select specific treatments. At this time, most psychotherapy techniques implemented for individuals without LD may be implemented with close progress monitoring for those with LD. Notwithstanding, there are certainly additional factors to consider for this population, including potential cognitive processing differences, the nature of the LD (e.g., basic reading), and various social and emotional challenges faced on a daily basis with the learning process. Clinicians will likely initiate a more effective therapeutic alliance if they have a good understanding of LD, in general, and the unique abilities of children and adolescents seen in therapy.

TRAUMATIC BRAIN INJURY

Traumatic brain injury (TBI) is defined as "an alteration in brain function, or other evidence of brain pathology, caused by an external force" (Brain Injury Association of America [BIAA], 2013). Within the larger group of causes of acquired brain damage, TBIs are separate from nontraumatic brain injuries, which result in brain damage that is not due to external physical force, such as brain tumors or vascular accidents. As such, the main difference between TBI and non-TBI is the presence of an external force impacting the skull and brain. Common causes of TBI include motor vehicle accidents, falls, gunshot wounds, and sports-related injuries (Bloom, Cohen, & Campbell, 2006).

Annually, 62,000 children sustain TBIs that require hospitalization and 564,000 visit emergency departments and do not require hospitalization (BIAA, 2013). TBI is the leading cause of death and disability in children and adolescents in the United States, with the two age groups at greatest risk for experiencing TBI being children between ages 0 to 4 and adolescents between ages 15 to 19 (BIAA, 2013). Males are at greater risk for suffering a TBI when compared to females, a difference with onset around the age of 5 that continues into adolescence. Causes of TBI also vary with age. For example, child abuse is a leading cause of brain injury among infants (roughly 25%; Wade, Walz, & Bosques, 2009), and falls account for more than half of TBIs for children under the age of 5. In the school-age years, pedestrian, bicycle, and motor vehicle accidents account for the majority of TBIs. Incidence rates increase each year from birth to age 14, then rise sharply beginning at age 15; motor vehicle accidents are thought to account for the majority of the increase (Bloom et al., 2006).

Overview of Pathophysiology and Impact of Traumatic Brain Injury

It is important to have a basic understanding of the pathophysiology of TBI and its impact on various aspects of central nervous system functioning as specific neurocognitive deficits and strengths should guide psychotherapeutic intervention. TBI injuries

result in primary and secondary phases (see Bloom et al., 2006). Primary injuries result in damage to tissue and bleeding directly resulting from the traumatic impact, while secondary injuries arise from complications from the initial injury.

Primary Injuries

In closed head injuries, an external force, such as hitting concrete during a fall, causes the brain to repeatedly contact the skull, damaging tissue with each impact. The damage occurs despite the brain being suspended in cerebrospinal fluid. Damage to the brain occurs at the point of impact (i.e., the coup) and at the brain area opposite the original point of impact (i.e., the countercoup). Brain damage frequently occurs at both the coup and contrecoup impact points. During impact, rough-edged bone within the front and base of the skull may preferentially damage the frontal and temporal lobes of the brain. The configuration of the skull helps explain how damage to the frontal and temporal lobes may occur when blows to the back of the head are experienced or when the head does not strike an external object, such as a windshield, during a motor vehicle accident (i.e., noncontact TBI). Rapid, twisting movements of the brain may also occur during impact and result in stretching, shearing, and tearing of blood vessels and nerve fibers. Damaged axons undergo a series of changes that may cause cellular death. Furthermore, neurons may also be damaged by excessive release of excitatory neurotransmitters after an injury.

Secondary Injuries

Secondary injuries are experienced from resultant physiological processes, such as hemorrhage, hematoma, and seizure. A hemorrhage occurs when blood from the vascular system contacts tissues of the brain, where the blood may cause damage. A hematoma (i.e., clotting of a mass of blood) may also occur due to broken blood vessels. Physiological problems may also yield secondary injuries; for example, anoxia (i.e., a lack of oxygen) or hypoxia (i.e., insufficient oxygen) may arise if cardiovascular damage occurs.

Outcomes

Bloom et al. (2006) reviewed neuropsychological, psychological, behavioral, and family outcomes for children and adolescents who had sustained TBI. Authors found that intelligence tends to stabilize 1-year postinjury with individuals performing better on verbal cognitive ability measures versus nonverbal ability. Difficulties with executive functioning, such as organizing, planning, and disinhibition were common for individuals sustaining a severe TBI and attention problems were frequently observed across all individuals with TBI. Memory and learning difficulties are also common, with slower rate of learning frequently found and verbal memory affected more than visual memory. Processing speed was slowed as a result of TBI and speech and language difficulties were common.

Within the group of speech and language outcomes, Bloom et al. (2006) also noted problems with understanding social communication as well as inferential language.

Common behavioral and psychological sequelae include externalizing and internalizing behavioral concerns. Common externalizing problems experienced by children and adolescents with TBI include inattention, hyperactivity, and impulsivity, with up to 44% of individuals meeting diagnostic criteria for attention-deficit/hyperactivity disorder (Bloom et al., 2006). Aggressive behavior is also sometimes exhibited as a result of TBI. Internalizing disorders frequently arise as a result of TBI, with up to 25% of individuals with severe TBI meeting criteria for a depressive disorder. Children and adolescents with TBI also exhibit a range of social difficulties, such as social problem solving, managing social conflict, and coordinating play activities to fit those of peers. In general, poorer outcomes are experienced for children when the injury is of greater severity and at a younger age. The presence of family conflict and psychiatric disorder within the family also predict poorer outcomes for children.

Special Education Considerations

TBI is identified as a special education category and requires public schools to provide children and adolescents with TBI a free and appropriate education if TBI is negatively impacting on the student's academic attainment. Appropriate educational services may take the form of accommodations within general educational settings or other special education service delivery models. More restrictive special education service models include placement in a resource classroom setting or within a self-contained special education placement, depending on the needs of the child or adolescent. Speech/language, occupational, and physical therapies may also be provided as related services, depending on the neurocognitive impact of the child's injury. It is likely that children and adolescents with moderate to severe TBI will need special education services and that such services will be provided for much of the child's education.

Special Issues and Social-Emotional Concerns

Novel attention difficulties, depression, anxiety, and behavior problems arise for a large minority of children and adolescents experiencing TBI. Social difficulties may also arise due to injuries, such as difficulties with accurately decoding and interpreting social information and exhibiting impaired social judgment. For many children with TBI, depression, low self-esteem, and frustration may arise due to loss of previously acquired academic, motor, and language skills. Motor impairments may compound social difficulties, such as a student with TBI who is unable to join peers during playground activities or participation in sports. Family coping and psychological functioning are often affected by TBI and, in turn, impact long-term outcomes. Given the complex interplay of factors involved in TBI, biopsychosocial models are offered to guide coordinated

intervention efforts. Biopsychosocial models emphasize the roles of biological factors, such as location and severity of the TBI, psychological factors, such as the child's cognitive appraisal of the TBI and concomitant anxiety or depression, and social factors, such as the impact of TBI on parenting stress and quality of educational support. A general biopsychosocial conceptualization is helpful when thinking about hospitalization and school re-entry experiences for children and families affected by TBI.

Hospitalization

Although experiences vary depending on the severity of TBI, children sustaining TBI will likely be seen in emergency departments, admitted for clinical care, and may experience lengthy admissions in rehabilitation hospitals to facilitate recovery. The circumstances regarding the injury may prove traumatic for both child and family and may necessitate psychotherapeutic intervention. Children and adolescents with various illnesses and injuries may experience pediatric medical traumatic stress (PMTS), which is defined as psychological and physiological responses of children and families related to illness, injury, and invasive or frightening treatment experiences; PMTS includes acute stress disorder and posttraumatic stress disorder (PTSD; Kazak, Schneider, & Kassam-Adams, 2009). Kazak et al. (2009) describe a three-phase model of medical trauma staged according to the timing of the medical event: (1) Phase I: Peritrauma (During and Immediately Following the Medical Event); (2) Phase II: Early, Ongoing and Evolving Responses, and (3) Phase III: Longer-term PMTS. Goals for therapy differ across phases. The therapeutic goal for Phase I is to alter the subjective experience of the medical event, the goal for Phase II is to reduce or prevent PMTS, and the goal for Phase III intervention is to treat symptoms of PTSD. In Phase III, Kazak et al. (2009) recommend a combination of cognitive-behavior and family therapy.

School Reentry

For children and adolescents with TBI, particularly those with moderate to severe injuries requiring hospitalization, the timing and process of reentering the school environment are important clinical decisions to consider. For children with TBI and other chronic illnesses, the general belief is that return to pre-injury or prediagnosis activities as soon as medically feasible facilitates rehabilitation and psychological adjustment (Madan-Swain, Katz, & LaGory, 2004). During medical stabilization and subsequent rehabilitation, children and adolescents with TBI will likely be absent from school and have little contact with peers and school professionals. Many regular and special education teachers report little prior experience working with children with TBI and will likely need assistance and ongoing consultation with others, such as pediatric psychologists, school psychologists, speech-language pathologists, among others, to support the child's educational needs. Peers may also have questions about the

circumstances regarding the child's TBI and may need specific guidance and instruction regarding how best to support their classmate with TBI.

Madan-Swain et al. (2004) describe a three-phase school reentry model for children with TBI and other health conditions that target the needs identified above. Phase I involves initial hospitalization, planning for homebound instruction, and planning for school reentry. Critical therapeutic goals and activities are to emphasize the importance of return to school as well as to coordinate hospital and school planning. Phase II involves contact with and education of school personnel. Phase II activities emphasize educational assessment and programming, education of and consultation with teachers and school personnel, peer education, and family support. Within Phase II, IEP development and initial implementation occurs. Phase III involves follow-up contact with the family, school professionals, and medical team members. Clinical activities within Phase III center on ongoing consultation and modification of school-based services as needed.

Family and Parent Issues

TBIs affect parents and families in various areas. Parents report significant levels of burden and distress, with as many as one-third of caregivers experiencing significant levels of anxiety, depression, and social adjustment difficulties, particularly when the TBI is severe (Hawley, Ward, Magnay, & Long, 2003). For children who require hospital admission, parents may worry about the survival of their child, and may experience feelings of guilt regarding the circumstances of the injury (Hawley et al., 2003). As many as 41% of parents report a significant increase in parenting stress due to their child's TBI (Hawley et al., 2003). Increased stress is likely due to the increased dependency of the child with TBI. Due to increased stress and negative emotionality experienced as a result of their child's injury, parents often warrant psychotherapeutic intervention. The functioning of parents and family, however, also predict child outcomes directly or indirectly and family-based intervention has been shown to be beneficial in multiple areas, including reducing parenting stress and improving children's behavioral adjustment.

Therapeutic Approaches

Several published reviews of the TBI intervention literature have concluded that much more is known regarding behavioral and emotional *outcomes* for children with TBI when compared to social-emotional and behavioral *interventions* to improve such outcomes (e.g., Warschausky, Kewman, & Kay, 1999). As with other intellectual and developmental disabilities, the dominant approach is based on behavior therapy that targets specific problem behaviors during intervention. There are, however, several cognitive and family-based interventions that have been developed, utilized, and evaluated for children with TBI.

Behavioral Approaches

Review of the TBI intervention literature reveals that the majority of published work employs behavioral interventions that are typically grounded in methods of applied behavior analysis, such as understanding the antecedent and consequent conditions associated with specific behaviors (see Laatsch et al., 2007; Slifer & Amari, 2009, for reviews). Various behavioral approaches, such as operant and antecedent interventions, have been utilized to manage and reduce impulsive, aggressive, and disruptive behaviors, so-called squeaky wheel behaviors (Warschausky et al., 1999) exhibited by children and adolescents with TBI. The evidentiary support for using behavioral therapy relies on findings from single-case research designs. Varied behavioral targets, such as verbal aggression, physical aggression, noncompliance, impulsivity, and screaming, have responded to applied behavioral intervention methods. Behavioral interventions shown to be effective in reducing problem behaviors have also ranged widely including differential reinforcement of other behavior, token economies, extinction, time-out procedures, and combinations of behavioral techniques. Behavioral interventions targeting problem behaviors have also been delivered successfully across varied contexts, such as within rehabilitation programs, residential schools, public schools, or within the child's home (Ylvisaker et al., 2007).

Family Therapy and Parent Intervention

As noted earlier, TBI impacts family functioning which is associated with various child outcomes. Despite consensus that family functioning is a critical area for intervention, few systematic interventions have been developed and evaluated to date. One notable exception is a family-centered problem-solving intervention (FPS) developed and evaluated by Wade, Michaud, and Brown (2006). FPS is a structured family-based intervention designed for implementation over a 6-month period using seven biweekly therapy sessions to provide orientation and training in the problem-solving approach and up to four additional sessions to address other problems encountered by the family. Each session consists of a didactic component and applied problem-solving component. Didactic content consists of TBI-tailored information about the possible effects of TBI on memory, attention, learning, and behavior as well as strategies to address such difficulties. Other didactic content focuses on family communication, handling family crises, and structuring the environment to facilitate optimal adjustment for the child with TBI.

The FPS intervention employs a five-step problem-solving skills framework, referred to as the *ABCDE* model. The five steps of the ABCDE model consist of (a) identifying targeted problem areas (i.e., *A*ims phase), (b) generating solutions to solve the problem (i.e., *B*rainstorming phase), (c) selecting a solution from those generated

(i.e., Choosing phase), (d) implementing the solution selected (i.e., *D*o it phase), and (e) determining if the enacted solution was successful (i.e., *E*valuation phase). The general goals of FPS therapy are to engender a positive approach to solving problems and equip the family with skills to solve problems after therapy completion. That is, the ABCDE model of problem solving is designed to be applied to new problems that may arise after FPS therapy is ended.

Using an RCT design, Wade et al. (2006) contrasted child adjustment and parental distress outcomes between FPS and a usual care condition. Analyses revealed significant differences in parent-rated child internalizing problems, anxiety, depression, and social withdrawal in favor of FPS. Parental distress and parent-child conflict did not differ across groups nor change over time as a result of either FPS or standard care. Overall, initial findings suggest a family-centered problem-solving approach is beneficial in improving child internalizing behaviors.

Investigators have also targeted reduction of parenting stress within a small group therapy format. Singer et al. (1994) evaluated the impact of a 9-week stress management program specifically targeting parents of children with brain injury, mostly TBI. The stress management program consisted of psychoeducational instruction in coping skills and parent-to-parent social support. For each 2-hour session, the therapist introduced, taught, and modeled specific coping skills, such as progressive muscle relaxation, monitoring stress levels, and altering negative self-talk during stressful situations. Group participants practiced skills and completed homework assignments between group sessions with weekly phone contact provided to help with homework assignments. Authors evaluated the benefits of the stress management program in contrast to an information and emotion support group program. Statistical analysis revealed significant reductions in parent-reported depression and anxiety for parents in the stress management program when compared to the informational group. The findings suggest that explicit training and practice in active coping for parents may reduce stress, improve psychological functioning, and, ultimately, improve family functioning and child mental health outcomes.

Social Interventions

Children with TBI report social outcomes as more important than academic, physical, or sports-related functioning; however, social interaction difficulties are frequently encountered by the group. A few investigators have delivered intervention within the context of school-based social networks (see Warschausky et al., 1999, for a brief overview). Social network interventions target development of a supportive team of peers, teachers, and parents to increase social contact, social acceptance, and social interactions within the school setting. Research findings suggest that, unfortunately, initial social benefits are not sustained when the coordinating therapist ends involvement in the intervention (Warschausky et al., 1999).

PHYSICAL DISABILITY

The term physical disability is used variably in the literature and sometimes includes children with acquired brain and spinal cord injury or chronic health conditions, such as asthma, and sometimes not. For the purposes of the chapter, the authors adopt an inclusive use of the term *physical disability* to describe children covered by the orthopedic impairment and other health impairment (OHI) categories of special education established in IDEA (2004). As such, the definition for orthopedic impairment is:

> Orthopedic impairment means a severe orthopedic impairment that adversely affects a child's educational performance. The term includes impairments caused by a congenital anomaly, impairments caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).

Similarly, the federal definition of OHI follows:

> Other health impairment means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that (i) Is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome; and (ii) Adversely affects a child's educational performance.

As reflected in the IDEA definition, a wide range of causes of orthopedic impairment is captured, including various congenital anomalies and inherited conditions, such as spina bifida and Duchenne muscular dystrophy. The definition also includes diseases that may cause orthopedic impairment, such as juvenile rheumatoid arthritis or various childhood cancers, such as sarcomas. A range of other causes are included in the final portion of the IDEA definition, such as broken bones, amputations, or burns. The final definition also includes mention of contracture, which is a fixed tightening of muscle, ligaments, tendons, or skin that prevents normal movement of a part of the body. For example, a severe hand burn may cause contracture of skin that limits finger movements and reduces functional skills. Likewise, the special education category of OHI includes various chronic illnesses that may affect educational performance.

Special Issues and Social-Emotional Concerns

Similar to TBI and the larger literature on pediatric illness and injury, a general approach to intervention with children and adolescents with physical disabilities should be grounded in a biopsychosocial conceptualization. Although general

biopsychosocial models are helpful in understanding psychosocial risks and planning clinical intervention, children with differing physical disabilities appear to experience different risks for adjustment problems and psychological difficulties. For example, children with physical disabilities and chronic illness that affect the central nervous system (CNS) may experience greater academic and learning difficulties. A few illustrative examples follow within the brief overview of social-emotional concerns for children and adolescents with physical disabilities.

Children with physical disabilities and chronic illnesses are more depressed than typical peers; however, children with fibromyalgia, cleft lip and palate, and epilepsy, among others, experience greater degree of depression within the larger group of children with physical illness (Pinquart & Shen, 2011a). Children with physical disabilities demonstrate higher levels of internalizing, externalizing, and total behavior problems when compared to typical peers (Pinquart & Shen, 2011b). Some variability exists within the published literature, however, with students with epilepsy and chronic headaches demonstrating higher levels of externalizing problems when compared to other children with physical illnesses.

Children with physical disabilities and chronic illness also experience lower levels of academic, physical, and social functioning when compared to typical peers (Pinquart & Teubert, 2012). As may be expected, impairments related to physical functioning are greater than both academic and social functional impairments. Children with spina bifida and cerebral palsy are also more likely to experience difficulties with academic, physical, and social functioning when compared to other groups of children with chronic physical conditions (Pinquart & Teubert, 2012). The belief is that spina bifida, cerebral palsy, and other disorders that affect CNS functioning result in cognitive impairments that affect academic learning and accurate understanding of social information.

Family and Parent Issues

As with other disabilities, physical disability is often associated with increased parenting stress. Parent-child relationships and parenting behaviors also differ between families with a child with chronic illness and those without (Pinquart, 2013). Parent-child relationships tend to be less positive and characterized by lower levels of parental responsiveness and less warmth when compared to families of healthy children. Parent-child relationships for children with epilepsy are found to be more affected, in general, than other groups of children with physical disability (Pinquart, 2013). Parents also demonstrate higher levels of demandingness as evidenced by controlling parenting behavior and overprotectiveness when compared to parents of healthy children.

Physical disability and chronic illness also affect siblings' adjustment and well-being. A comprehensive review documented that siblings' emotional and behavioral adjustment is negatively affected by presence of chronic illness (Sharpe &

Rossiter, 2002). Siblings experience more internalizing problems, such as anxiety and depression, than externalizing problems, such as aggression. Sibling self-concept and peer activities are also negatively impacted by the presence of chronic illness. Across the board, however, parent-reported problems are more negative when compared to sibling-reported problems, which may reflect parent sensitivity to negative outcomes for siblings (Sharpe & Rossiter, 2002). Sibling adjustment was also more negatively affected when the illness proved more disruptive to daily family functioning, such as cancer and diabetes, when compared to less disruptive conditions, such as craniofacial anomalies.

Therapeutic Approaches

Psychotherapy utilized with children and adolescents with physical illness may target a range of presenting concerns, such as increasing compliance with medical regimens, managing pain, reducing anxiety related to medical procedures, and increasing family functioning. Published research documents the benefits of psychotherapy for management of disability and illness as well as improving emotional and behavioral adjustment (Kibby, Tyc, & Mulhern, 1998). Well-supported evidence-based interventions also exist for managing pain associated with physical disabilities and chronic illnesses (Spirito & Kazak, 2006). Similarly, evidence-based interventions exist for reduction of anxiety and increased coping during medical procedures. Similar to the larger literature on child psychotherapy, the majority of evidence-based interventions employ behavioral and cognitive-behavioral methods.

Behavioral Therapy

Behavioral techniques are well-supported for use with children with physical disabilities and chronic illness (Spirito & Kazak, 2006). Staple relaxation techniques have been used with this group, such as meditative breathing, diaphragmatic breathing, imagery-based relaxation, and progressive muscle relaxation (PMR). Relaxation techniques are portable and may prove helpful across various contexts, such as managing pain, tolerating medical procedures, and decreasing symptoms of anxiety. Breathing and PMR must be tailored for use with children with chronic illness as pulmonary and muscle functions may be compromised for some children. If PMR is not possible, imagery-based relaxation techniques should be considered.

If relaxation techniques will be utilized, the therapist should provide a rationale and description for the techniques; the justification should also be shared with parents, who may become incorporated as coaches for practice and prompting children to use relaxation. Spirito and Kazak (2006) describe a set of helpful preparatory steps to assess children's abilities to use imagery, capacity to hold their breath, choices of adjectives (e.g., warm; yellow) to describe feelings of relaxation, and selections of favorite places

(e.g., beach) to utilize in relaxation scripts. Spirito and Kazak (2006) include detailed scripts for use and adaptation for children that incorporate meditative breathing, imagery-based relaxation, and self-directed imagery to achieve a deepened relaxation state. The scripts are designed to provide a general framework for relaxation and should be tailored for use with the individual by incorporating choice of adjectives, favorite places, and pacing of the script.

Various behaviorally based approaches have been utilized with children with physical disabilities and chronic illness. Operant approaches may be utilized to increase functional independence, improve compliance with medical procedures, and reduce externalizing behavior. As with other reinforcement-based techniques, targeted behaviors should be clearly defined, reinforcers carefully selected, and reinforcement delivered consistently. Token economies may be utilized across various contexts, such as on a pediatric ward or within the home.

Cognitive Techniques

Cognitive-behavioral therapeutic techniques have also been utilized and supported for children with physical disabilities and chronic illness. Problem-solving methods are organized and sequential cognitive techniques designed to increase children and adolescents' cognitive flexibility and selection of adaptive solutions to various problems encountered. An approach recommended for use with children with physical disabilities and chronic illness is the "SOLVE" model. The SOLVE model utilizes five basic steps, with each step corresponding with a letter in the acronym. The S stands for "select a problem," O is "options," L stands for "likely outcomes," V is "very best one," and E stands for "evaluate" (see Spirito & Kazak, 2006, for sample script). The therapist introduces the model, reviews the steps involved with SOLVE, and illustrates the steps with a relevant decision, such as an adolescent's nonadherence to treatment.

Cognitive coping skills are also recommended for use with children with physical disabilities and chronic illness to manage symptoms of anxiety and depression. As with relaxation techniques, cognitive coping skills are portable, flexible, and applicable to various clinical problems. The general approach is to provide a developmentally appropriate description of the role of negative self-statements in signaling and exacerbating feelings of anxiety or depression and teaching adaptive self-talk (Spirito & Kazak, 2006). Identifying and countering negative self-statements are active ingredients in cognitive coping skills training and may be followed by an abbreviated relaxation procedure if the goal is to reduce anxiety. For younger children, tangible reinforcement, such as selecting a small prize or toy, is recommended for reinforcing efforts with cognitive coping procedures. Therapist modeling of cognitive coping and, if applicable, relaxation are also recommended when using this procedure.

Family Interventions

Given the impact of physical disability and chronic illness on the family system, family-based interventions have been developed and utilized. Several empirically supported family-based interventions exist for children with physical disabilities and chronic health conditions. The goals of family intervention may be to provide general supportive psychotherapy as families cope with physical disability; however, targeted family interventions appear to be more beneficial, such as improving adherence to treatment, reducing distress associated with medical procedures, and providing psychoeducation to the family to increase disease-specific knowledge and management (Spirito & Kazak, 2006).

Several structured protocols exist with evidentiary support for specific difficulties encountered with different conditions, such as adherence with treatment for diabetes and psychoeducational family therapy for sickle cell disease. A good example of a manualized family-based program targeting a specific problem associated with a specific disorder is the Surviving Cancer Competently Intervention Program (SCCIP), which is designed to reduce the distress associated with cancer and its attendant treatment (Spirito & Kazak, 2006). SCCIP is a single-day manualized intervention targeting reduction of posttraumatic stress symptoms for adolescent cancer survivors and their families. SCCIP is delivered in a group format and the single day is divided into four sessions that total five hours. Group content centers on cognitive-behavioral techniques that include linking antecedent triggers, such as follow-up clinic appointments, to beliefs, such as thoughts about recurrence, to emotional consequences, such as fear and anxiety. Participants are taught how to use reframing techniques to minimize the impact of negative thoughts, such as accepting uncontrollable aspects of the situation, focusing on what is controllable, and emphasizing the positive aspects of situations. SCCIP also includes multifamily group discussions regarding how cancer has impacted their families, how they have coped previously, and how skills learned during the intervention may be used to positively impact their future adjustment (see Spirito & Kazak, 2006, for detailed information about session content).

Group interventions have also been shown to be helpful for improving siblings' adjustment across various domains for a range of conditions. Short-term sibling groups (e.g., 5- to 8-week sessions) have been shown to improve siblings' knowledge about their counterparts' illness as well as reducing preoccupying thoughts about the health of their brother or sister (Spirito & Kazak, 2006). Groups have also shown to be helpful in reducing siblings' internalizing symptoms of depression, anxiety, and health-related fears. For clinicians working with children with physical disability or chronic illness, we

recommend assessment of sibling adjustment and, if indicated, consider recommending sibling group intervention or individual counseling.

CONCLUSION

Children with developmental, intellectual, and physical disabilities benefit from counseling and psychotherapy. A growing number of well-supported individual and family-based psychotherapeutic interventions are available to address various psychological needs for the group of children with disabilities. Children with disabilities typically qualify for special education services and will usually receive educationally related services via IEPs; children are also likely to receive services within and outside of schools from various professionals, such as speech-language pathologists, occupational therapists, medical professionals, among others. Counseling and psychotherapy must be coordinated carefully to support therapeutic efforts of other professionals; therefore, consultation skills are important for the therapist. Special considerations for employing psychotherapy with children with disabilities include: (a) modifying therapeutic techniques to fit the child's cognitive, language, and communication strengths and preferences and (b) considering the child's functioning within a larger social-ecological context that includes the family, special education services, and other professionals, such as physicians, speech-language pathologists, and occupational therapists.

Due to stress associated with parenting a child with disability, parents may also be seen for counseling and psychotherapy. Parents may benefit from counseling separate from their children or the entire family may be involved in a family therapy approach. Several family therapy protocols are available across different disability groups with varied therapeutic goals, such as improving communication, fostering child independence, or teaching family problem-solving skills. Likewise, disabilities may negatively impact sibling psychological adjustment; therefore, sibling interventions may be warranted.

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Autism Spectrum Disorders

Organization for Autism Research

The Organization for Autism Research is a foundation aimed at funding applied research and disseminating evidence-based practice information for individuals and families affected by autism spectrum disorders. The website provides links to free, downloadable guides for parents, special educators, and individuals with autism.

http://www.researchautism.org/

Autism Speaks

Autism Speaks provides funding for biomedical research, advocacy, and public awareness about autism, and its effects on individuals, families, and society. Their website has useful information on autism for families and professionals.

http://www.autismspeaks.org/

Learning Disabilities

National Center for Learning Disabilities

The National Center for Learning Disabilities (NCLD) is a foundation that aims to improve the lives of individuals with learning difficulties and disabilities through empowering parents, enabling young adults, transforming schools, and creating policy and advocacy impact. The vision of the NCLD is to support a society in which every individual possesses the academic, social, and emotional skills needed to succeed in school, at work, and in life.

http://www.ncld.org/

Intellectual Disability

American Association on Intellectual and Developmental Disabilities

The American Association on Intellectual and Developmental Disabilities (AAIDD) promotes progressive policies, research, effective practices, and universal human rights for people with intellectual and developmental disabilities.

http://aaidd.org/

Traumatic Brain Injury

Brain Injury Association of America

The Brain Injury Association of America (BIAA) is a nationwide brain injury advocacy organization with the stated mission to advance brain injury prevention, research, treatment, and education to improve the quality of life for individuals affected by brain injury. The BIAA website provides age-related information regarding diagnosis, treatment, and outcomes for individuals and families affected by brain injury. The BIAA website includes recommendations for family and caregivers organized according to different phases of recovery, such as immediate hospitalization, rehabilitation, and returning home from hospitalization.

http://www.biausa.org/brain-injury-children.htm

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention maintain a website that contains updated information about prevalence, causes, and intervention guidelines for

individuals affected by traumatic brain injury across the lifespan. The website features age-specific information about causes, prevention, and intervention recommendations for infants and toddlers, youth, and adolescents.

http://www.cdc.gov/traumaticbraininjury/

Physical Disabilities

Roberts, M. C., & Steele, R. G. (Eds.). (2009). *Handbook of pediatric psychology* (4th ed.). New York, NY: Guilford Press.

The *Handbook of Pediatric Psychology* provides conceptual and theoretical overviews of working with children and families affected by various pediatric illnesses and conditions, including several highlighted in the present chapter. The handbook also features chapters focused on family-based intervention, school reentry, and peer-based interventions. The handbook serves as a helpful starting point for understanding unique aspects of various disabilities, such as spina bifida, juvenile rheumatoid arthritis, burns, and traumatic brain injury, among others.

Society of Pediatric Psychology Evidence-Based Resources

The Society of Pediatric Psychology, Division 54 of the American Psychological Association, maintains a website with accessible fact sheets about common pediatric conditions, including several disabilities discussed in the present chapter. Fact sheets provide information on the prevalence, etiology, consequences, and evidence-based psychological assessment and treatment of various conditions.

http://www.apadivisions.org/division-54/evidence-based/fact-sheets.aspx

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Author Index

Abramowitz, C. V., 18
Abramson, L. Y., 117
Adams, E., 137
Agaskar, V. R., 288
Akay, S., 102
Alarcón, R. D., 286, 296
Albano, A. M., 128
Albee, G. W., 285
Ale, C. M., 133
Alexander, C. M., 66
Alexander, J. F., 340
Alford, B. A., 120
Alicke, M. D., 197
Allan, J., 93
Allen, J. M., 259
Allsopp, M. A., 129
Almgvist, 366
Amari, A., 382
Amaya-Jackson, L., 134
Amidon, M., 361
Ammendola, E., 159
Anderson, C. M., 322
Anderson, S., 361, 364
Anichkina, A. Y., 282
Appio, L. M., 79
Arambula, D., 49
Arcidiacono, L., 359
Armstrong, S., 97
Armstrong, S. A., 104
Arredondo, P., 62
Arsenio, W. F., 137
Asarnow, J. R., 126, 139
Atkinson, D. R., 69
Atkinson, L., 369
Attwood, T., 364
Auerbach, R. P., 136
Austin, D. M., 263
Axline, V., 92, 93, 99, 109

Badaly, P., 376
Baggerly, J., 97, 98, 104
Bagner, D. M., 368
Bailey, A., 360
Bailey, C., 340
Bailey, K., 131
Baird, M. A., 343
Baker, J., 362, 363
Baker, J. A., 300
Baker, L., 340
Baldwin, S. A., 339
Balkin, R., 97
Bandura, A., 117, 163
Banks, J. A., 63
Bannink, F. P., 370
Barbarin, O. A., 78
Barley, V., 288
Barlow, D. H., 173
Barlow, S. H., 336
Barnhill, G. P., 362
Baron-Cohen, S., 360
Barrett, C. L., 16
Barrett, P. M., 128
Bartley, W. W., 159
Barton, C., 340
Baruth, L. G., 189–190
Basco, M. R., 115, 120
Baskin, E., 258, 264
Bassin, A., 253
Bateson, G., 280
Battachi, M. W., 359
Bavolek, S. J., 336
Beail, N., 369
Beal, D., 180
Bean, J. S., 259
Beck, A. T., 115, 118, 119, 120, 125, 142, 155, 163
Beck, J. S., 115
Belloiu, A., 171
Bender, W. N., 372
Bennett, M., 131
Bensaheb, A., 133
Berg, I. K., 281, 282, 287, 300, 301
Bergin, A. E., 15
Berkeley, S., 372
Berliner, L., 140
Berman, J. S., 19, 181
Bernal, M., 264
Bernal, M. E., 69
Bernard, M. E., 155, 170, 181, 182, 183, 186, 187, 191, 192, 194, 197
Bernstein, G. A., 134
Berry, J., 67
Berry, J. W., 68, 80
Bersoff, D. N., 32, 43, 44, 50
Bertolino, B., 281, 306
Bezonsky, R., 126
Biever, J., 306, 374–375
Bigelow, G., 258
Birdsall, B., 44
Blackard, S., 93
Blanchard, E. B., 117
Blanco, P., 106
Blaske, D. M., 341
Blissett, J., 125, 181
Block, M. A., 260
Bloom, J. S., 377, 378, 379
Bloomquist, M. L., 361, 364
Bluestone-Miller, R., 301
Bodine, R., 253
Bogels, S. M., 196
Bolton-Oetzel, K. B., 288
Bora, C., 187
Borda, C., 329
Borduin, C. M., 13, 341
Borum, R., 41
Boscolo, L., 331
Bosques, G., 377
Bower, E. M., 4
Boxer, P., 137
Boyd, J., 367
Boyd, J. D., 171
Bozarth, J. D., 96
Bozeman, B. N., 305
Bratter, T., 253
Bratton, 103
Bratton, S., xi, 91, 93, 97–98, 99, 102, 103, 104, 105, 106, 109
Bratton, S. C., 106
Bray, J. H., 50
Brechman-Toussaint, M., 132
Bregman, J. D., 363
Brehm, K., 300
Brody, C. W., 341
Brondino, M. J., 341
Brooks, R. B., 301
Brown, H., 341
Brown, J., 21
Brown, T. M., 382

Brown-Chidsey, R., 53
Browning, B. K., 367, 368, 370
Bruce, M., 368
Bryson, S. E., 360
Buggey, T., 363
Bujoreanu, S., 190
Burgess, P. M., 166
Burlingame, G. M., 21
Burrows-Horton, C., 303
Butler, A. C., 142

Calin, A., 190, 198
Campbell, J., xi
Campbell, J. M., 357, 361, 377
Campbell, L. F., 192
Campione-Barr, N., 7
Canino, I. A., 70
Canter, A., 50
Card, N. A., 137
Carlson, C., 303
Carlson, C. I., 303, 304
Carlson, G. A., 126
Carnes, P., 337
Carroll, L., 359
Casas, J. M., 66
Caselli, G., 159
Casey, R. J., 19, 181
Caterino, L. C., 362
Cauffman, E., 41
Ceballos, P., 103, 106
Cecchin, G., 331
Celani, G., 359
Chae, M. H., 68
Chalfant, A. M., 359
Chamberlain, P., 341
Chao, J., 362
Chapman, J. E., 142
Chard, K., xi, 115, 134
Chard, K. M., 144
Chavira, D. A., 131
Cheshire, A., 338
Choate-Summers, M. L., 130
Chorpita, B. F., 128
Choudhury, M. S., 125, 143
Christian, L., 363
Christian, M. D., 78
Christianson, S. L., 303
Christopherson, E. R., 20
Clark, D. M., 131
Clark, L., 190
Clark, M. D., 306
Clarke, 142
Claud, D., 21
Clemons, D., 306, 374–375
Cnaan, R. A., 73
Coats, K., 260
Coatsworth, J. D., 340
Cohen, D. J., 360
Cohen, J., 19, 98
Cohen, J. A., 134, 140
Cohen, M. J., 377
Collins, S., 368
Compton, S. N., 376
Comstack, C., 336
Condillac, R., 369
Conner, C. M., 360
Conoley, C. W., 298
Conrad, M. M., 81
Cook, K. T., 362
Cooper, J. O., 361
Copeland-Linder, N., 73
Corcoran, J., 298, 305
Corey, G., 298
Cornelius-White, J., 96
Cowen, E., 4
Cox, J. W., 21
Crabtree, V., 362
Crawford, D., 253
Crick, N. R., 137
Cross, W. E., 68
Crowley, M., 125
Crowley, S. L., 142
Cubberley, W., 258
Cummings, J., 26
Cunningham, P., 341
Curfs, L. M. G., 370
Curtis, N. M., 13

Dadds, M. R., 128, 188
Dakof, G., 342
Dallos, R., 306, 370
Danger, S., 106
Dare, C., 340
Darwin, C., 161
David, D., 159, 163, 171, 173, 184, 188, 190, 198, 199
David, O. A., xi, 155, 173, 184, 188, 198
Davis, D., 163
Davis, M. W., 298
Davis, N. O., 360
Davison, G. C., 192, 194
Deblinger, E., 140
De Jong, P., 287, 297, 306
Dekker, M. C., 366, 369
DeKraai, M., 49
Delaune, E., 361
Delmolino, L., 359
DeMartino, R. A., 19
DeMers, S. T., 49
Denckla, M., 360
Derks, J., 282
DeRubeis, R. J., 136
Desetta, A., 296
de Shazer, S., 281, 282, 287, 290, 291, 294, 297, 304, 326, 333
DeSimone, G., 362
Devries, R., 157
DeWit, D. J., 131
Deyhle, D., 80
Diamond, G. M., 342
Diamond, G. S., 342
Diekstra, R. F. W., 192, 193
DiGiuseppe, R., xi, 155, 156, 159, 162, 163, 164, 167, 173, 174, 175, 178, 179, 180, 181, 182, 183, 184, 186, 187, 188, 189, 190, 191, 192, 193
Dillman Taylor, D., 102
Dix, T., 188
Dobson, K. S., 118
Dodge, K. A., 4, 5, 137
Doherty, W. J., 343
Dolan, Y., 282
Dolan, Y. M., 282
Dolgin, K. G., 7
Doll, B., 4, 26, 300
Dollard, J., 117
Dominick, K., 360
Donovan, C., 132
Doss, A. J., 18
Dowd, E. T., 119
Dowling, E., 326
Doyle, K. A., 187
Dozois, D. J., 25
Dozois, D. J. A., 118
Drasgow, E., 54
Dreikurs, R., 233
Drewes, A., 91, 93
Dryden, W., 155, 156, 163, 173, 178
Dubow, E. F., 137
Ducharme, J. M., 376
Duchoslav, R., 125
Duffy, A. L., 128
Duncan, B., 21
Duncan, B. L., 285, 294
Dunne, A., 288
DuPaul, G. J., 372
Durand, H., 198
Durocher, J. S., 364
Dym, B., 333
D'Zurilla, T. J., 155, 181

Edwards, N., 93
Egan, G., 289
Einfeld, S. L., 366, 367
Eisler, I., 340
Elder, L. M., 362
Elliot, S. N., 50
Ellis, 184
Ellis, A., 117, 155, 156, 157, 159, 162, 163, 165, 169, 170, 173, 174, 178, 181
Ellis, D. A., 341

Ellis, L. A., 366, 367
Emerson, E., 366, 367
Emmelkamp, P. M., 196
Engel, G., 328
Engels, G. I., 192, 193
English, J., 257
Englund, S., 253
Epston, D., 326
Erwin, J. C., 253
Esposito, M. A., 192, 193
Estes, A., 364
Everall, R. D., 288
Eyberg, S. M., 368
Eysenck, H. J., 14, 17

Farrell, W., 198, 254
Fauber, R. L., 119
Fedewa, A., 287
Fedewa, A. L., ix, 1, 25
Feeny, N. C., 132, 135
Feldman, M. A., 369
Field, A. P., 119
Field, C., 125
Fine, M. E., 338
Fisch, R., 280, 323
Fischer, A. R., 79
Fischer, L., 43, 45, 48, 52, 54
Fisher, B. L., 336
Fishman, H. C., 329
Fiske, S. T., 283
FitzGerald, D. P., 137
Flahive, M. W., 104
Flanagan, D. P., 40
Fleuridas, C., 331
Flynn, M., 81
Folstein, S., 360
Ford, E., 253
Ford, L., 54
Ford, P. W., 192, 193
Forman, E. M., 142
Forness, S. R., 372–373
Forrester, L., 129
Foti-Gervais, L., 369
Franco, N., 133
Frank, J. B., 286, 296
Franklin, C., 282, 283, 298, 302, 305, 306, 374–375
Frea, W. D., 363
Freake, H., 288
Freeman, A., 163
Freeman, J., 326
Freud, S., 2
Frey, M. A., 341
Friedman, A. S., 341
Friedman, M. S., 74
Friedman, R., 338
Frith, U., 360
Froeschle, J., 298, 306
Fuller, G. B., xi, 217
Funk, R. R., 288

Gagnon, E., 363
Galloway, 193
Garcia, J. I. R., 81
Garfield, S. L., 15
Garnefski, N., 192, 193
Garner, B. R., 288
Garrett, M. T., 79, 80
Garza, Y., 106
Gassman, D., 286
Gavita, O. A., 173, 190, 198
Gelles, R. J., 73
George, J. C., 45, 48
Gergen, K., 281
Gil, E., 91, 94, 334, 335
Gilgun, J. F., 79
Gillaspy, A., 294
Gilliland, B., 224
Gilman, R., xi, 115, 134
Gingerich, W. J., 282, 290, 305
Ginott, H. G., 92, 103
Ginsburg, G. S., 135, 139, 140
Glass, G. V., 18, 19, 192
Glasser, N., 218, 219, 253
Glasser, W., 217, 218, 219, 220, 223, 224, 226, 236, 242, 245, 251, 252, 254, 265
Glossoff, H. L., 37
Godley, S. H., 288
Gold, J., 137
Goldenberg, H., 318
Goldenberg, I., 318
Goldman, E. B., 43, 45, 48
Goldner, V., 322
Goldstein, S., 301
Gonzales, T., 106
Gonzalez, 193, 196
Gonzalez, S., 337
Good, P., 253
Goodrich, T. J., 322
Gordon, E. A., 119
Gorman, B. S., 139
Gormley, M. J., 372
Gorter-Cass, S. E., 259
Gossen, P., 253
Gossette, R. L., 192, 194, 197
Goto, S., 81
Gotterbarn, R. C., 180
Gottlieb, M. C., 31
Grant, F., 256
Grant, S., 300
Grave, J., 125, 181
Graves, D., 198
Grawe, K., 286
Gray, C., 362, 363
Greenbaum, P., 342
Greene, A. F., 40
Griger, R. M., 171
Grisso, T., 49, 50
Groden, J., 363
Grunwald, B., 233
Guerney, B., Jr., 93
Guerney, L., 92, 93, 103, 105
Guerra, N. G., 138
Gunn, W. B., Jr., xi, 317
Gurman, A. S., 339, 340
Guthrie, D., 134
Gutkin, 193
Gutkin, T. B., 50

Haaga, D. A., 192, 194
Hagen, K. A., 341
Hagopian, L. P., 369
Hajzler, D. J., 192, 194
Hale, J. V., 263
Haley, J., xi, 280, 317, 320, 330
Halliday-Boykins, C. A., 341
Hambidge, G., 92
Hammond, R., xi
Hammond, R. K., 357, 360
Hampe, I. E., 16
Hanley, J. H., 341
Hansen, C., 133
Hansen, J., 192, 195
Hansen, N., 40
Hanson, M. J., 63
Hansson, K., 341
Happe, F., 360
Hardiman, R., 69
Hare-Mustin, R. T., 322
Harmell, P. H., 46, 47, 52
Harris, A., 54
Harris, M. A., 260
Harris, M. B., 302
Harris, S. L., 359
Hart-Hester, S., 258
Hartshorne, T., 26, 28, 32, 34, 35, 36, 38, 39, 40, 41, 44, 47, 49, 50, 51, 53, 54
Hartzell, M., 105
Harvey, R. G., 332
Harvey, V., 262
Harwood, H. R., 372
Hashemi, A., 126
Hawes, R. M., 255
Hawley, C. A., 381
Hawley, K. M., 18
Haydicky, J., 376
Hayes, S., 192, 195
Hayes, S. C., 115, 173
Haynes, K. N., 171
Hays, J. R., 50
Hays, P. A., 40, 322
Heath, N., 119

Hedtke, K. A., 376
Hefner, K., 296
Heiblum, N., 341
Heider, F., 117
Heimberg, R. G., 119
Helker, W., 106
Helms, J. E., 69
Henderson, C., 342
Hendrick, S., 282
Henggeler, S. S., 13
Henggeler, S. W., 341
Hepburn, S., 362, 364
Herlihy, B., 35, 44
Hernandez, B., 81
Hernández, P., 323
Heron, T. E., 361
Hervis, O., 340
Hess, R., 258, 264
Heward, W. L., 361
Hickman, J., 303
Hildebrand, M., 196–197
Hill, R. B., 78
Hinton, S., 364
Hirsch, C. R., 131
Hoffman, J. M., 360
Hogg, V., 282
Hoglund, R., 253
Holland, L., 125
Holleb, L., 134
Holliman, R., 106
Holt, P., 338
Hoopes, M. H., 336, 337
Hopson, L., 298, 306
Hough-Waite, L., 257
Howlon, P., 360
Huang, L., 4, 5
Huber, C. H., 189–190
Hubert, M., 44
Hudson, J. L., 128
Huesmann, L. R., 137
Huey, W. C., 35, 36, 55
Hug-Hellmuth, H., 92
Hulteng, R. J., 43, 45, 48
Hunter, M. L., 255
Hurley, A. D., 368, 369
Hwang, W. C., 81

Idalski, A., 341
Iivanainen, 366
Imber, S., 257
Imber-Black, E., 331, 332
Inch, R., 306
Inoff-Germain, G., 129
Ionutiu, D. R., 190
Isaacs, L., 342
Isaacs, M. L., 37
Isebaert, L., 282
Ivery, J., 305
Ivey, A. E., 66
Ivey, M. B., 66

Jackson, D., 253
Jackson, M. L., 82
Jacob, S., 26, 28, 32, 34, 35, 36, 38, 39, 40, 41, 44, 47, 49, 50, 51, 53, 54
Jacobs, R. H ., 136
Jacobson, N., 173
Jacob-Timm, S., 54
Jagim, R. D., 43
James, R., 224
James, W., 116, 164
Jayne, K., 91, 97
Jenkins, O. B., 63
Jennett, H. K., 369
Jilton, R., 182
Johnson, B., 4, 157
Johnson, C. P., 359
Johnson, J. H., 34, 37, 38, 39
Johnson, K., 119
Johnson, L. M., 328
Johnson, S. P., 104
Johnson, W., 156
Jonas, L., 91
Jones, A. C., 79
Jones, J., xi, 61
Jones, J. M., 64, 66, 69, 70, 71, 75, 78, 79, 81
Jorm, A. F., 192, 194
Josephson, A., 364
Joyce, 198
Joyce, M., 181, 183, 187, 190

Kamps, D., 363
Kapche, R., 54
Karver, M. S., 288
Kaslow, N. J., 127, 192
Kassam-Adams, N., 380
Kassinove, 184
Kassinove, H., 139, 198
Katz, E. R., 380
Kavale, K. A., 372–373, 375
Kay, J., 381
Kazak, A. E., 380, 386, 387, 388
Kazdin, A. E., 3, 4, 12, 20, 125, 188, 197
Kearney, C. A., 133
Keat, D. B., 12
Keeling, K., 363
Keeney, B., 324
Keith-Spiegel, P. C., 33, 34, 35, 36, 39
Kellam, T., 93
Kelly, G., 158
Kelly, G. A., 117
Kelly, M. S., 301, 306
Kelter, J., 187, 188, 189
Kendall, P. C., 115, 125, 127, 128, 139, 142, 143, 171, 376
Kennard, B. D., 135
Kent, G., 288
Kerzbeck, U., 296
Kewman, D., 381
Kibby, M. Y., 386
Killian, K., 322
Kim, J., 68
Kim, J. A., 360, 363
Kim, J. S., 305, 306
Kim, U., 68
King, N. J., 134
King, R., 368
Kitano, H. H. L., 68
Klein, M., 2, 92
Klein, N. C., 340
Klin, A., 360
Klotz, M. L., 197
Knapp, S., 50
Knaus, W., 186
Knell, S., 93
Knight, G. P., 69
Kniskern, D. P., 339, 340
Koegel, R. L., 363
Koeske, G. F., 74
Koocher, G. P., 33, 34, 35, 36, 39
Koot, H. M., 366, 369
Kopec, A. M., 180
Kornreich, M., 367
Korr, W. S., 74
Koskentausta, 366
Kottman, T., 93
Kovacs, M., 143
Krantz, P. J., 363
Kravits, T., 363
Krebs, P. M., 174
Kuhn, T., 163
Kunze, K. S., 260
Kurasaki, R., 170

Laatsch, L., 382
Labarrie, T. L., 79
Lacourt, M., 282
LaFavor, T., 13
LaGory, J., 380
Lainhart, J., 360
Lambert, M. J., 15, 21, 294
Lambert, S., 91, 109
Lambie, G. W., 373
Landreth, G., 91, 92, 93, 97–98, 99, 101, 103, 104, 105, 106, 107, 109
Lang, R., 361, 362
Langdon, P., 368
Langley, A. K., 129
Laracy, S. D., 372

Larres, C., 68
Lasts, C. G., 133
Laurent, A. C., 361
Lavy, E. H., 196–197
Lawson, D., 290
Lazarus, A., 117
Lazarus, A. A., 12
Lazarus, R. S., 171
Leaf, R., 174
Leahy, R. L., 117
Lee, A. C., 92
Lee, K., 106
Lee, L., 279
Lee, M. Y., 282, 306
Leekam, S., 359
Leibert, T. W., 288
Leichtentritt, J., 373
Leitch, R., 288
Leong, F. T. L., 79
Lerner, J. S., 119
Letourneau, E., 341
LeVasseur, P., 363
Leve, L. D., 341
Levitt, E. E., 16, 17
Levitt, T., 279
Levy, D., 92
Lewis, R. L., 73
Lewis, V. E., 261
Lichtenstein, R., 372
Liddle, H., 342
Liddle, H. A., 341
Lin, Y., 97–98
Lindquist, B., 338
Linehan, M. M., 115
Linssen, F., 296
Lipchik, E., 282, 304
Lipps, C., 196
Liscio, M., 301
Litrell, J. M., 281
Little, T. D., 137
Litwack, L., 220, 253
Lloyd, H., 306, 370
Lobovitz, D., 326
Lochman, J. E., 137
Lombard, T. J., 51
Long, J., 322, 381
Lord, B. D., 263
Lord, C., 360, 361, 363
Lovejoy, M. C., 190
Lundahl, B., 190
Lynch, C., 298
Lynch, E. W., 63
Lynn, S., 159
Lyons, L. C., 192, 194, 197

Maaskant, M. A., 370
MacDonald, A. J., 305
MacDuff, M. T., 363
Mac Kune-Karrer, B., 322
MacLean, G., 92
Madanes, C., 331
Madan-Swain, A., 380, 381
Magnay, A. R., 381
Maguth Nezu, C., 155, 181
Mahoney, M., 159, 192, 194
Mahoney, M. J., 118
Mahoney, R., 361
Malley, P., 41
Manassis, K., 141, 142
Mancina, C., 363
Mancini, C., 131
Mandelbaum, D. E., 359
Mannarino, A. P., 140
Marandola, P., 257
Marcek, J., 322
Marner, T., 326
Martin, P. P., 73
Martinez, R. S., 374
Martucci, L., 255
Mash, E. J., 25
Mathai, G., 359, 361, 364
Matson, J. L., 367, 369
Matthews, D. B., 255
Mattila, M., 360
Maultsby, M. C., 163
Mazefsky, C. A., 360
McBride, C. K., 340
McCarthy, J., 367
McCarthy, M., 192, 195
McCarty, M. A., 142
McClannahan, L. E., 363
McCollum, E. E., 282
McDavis, R., 62
McDowell, N. K., 119
McDowell, T., 323
McGee, J., 361, 363
McGee Banks, C. A., 63
McGoldrick, M., 321
McGovern, T., 192, 195
McGovern, T. E., 192, 195, 196
McGrew, J., 359, 364
McGuiness, T., 250
McGuire, C. V., 283
McGuire, W. J., 283
McHale, S. M., 73
McHugh, T. A., 188
McKeel, J., 305
McLaughlin, K. A., 139
McLeod, B. D., 139, 288
McMahon, J., 195, 197
McNamara, J., 372, 374
Meadows, S., 125
Mearns, D., 96
Meichenbaum, D., 155, 163, 181, 184
Meichenbaum, D. H., 117
Melfsen, S., 133
Melton, G. B., 341
Meltzoff, J., 367
Merriefield, C., 184
Merriefield, R., 184
Mersch, P. P., 196–197
Mesibov, G. B., 359, 363
Metcalf, L., 282, 298, 300, 302
Metzger, A., 7
Meyer, C., 46
Meyer, J. A., 364
Meyer, R. S., 54
Michael, K. D., 142
Michaud, L., 382
Miller, L., 16
Miller, N. E., 117
Miller, N. J., 192, 193, 198
Miller, S., 21, 192, 195
Miller, S. A., 125
Miller, S. D., 288
Miller, V. A., 132
Miller, W., 182
Milligan, K., 376
Mills, M. J., 48
Milson, A., 373
Minde, K., 126, 128
Minde, T., 68
Mink, J. W., 359
Minshawi, N. F., 367
Mintz, J., 139
Minuchin, S., 320, 321, 329, 340
Mireas, R., 306
Mishna, F., 374, 375
Miville, M. L., 69
Mok, D., 68
Molnar, A. E., 338
Monga, S., 129
Montesi, J. L., 119
Moon, M., 262
Moore, K., 298, 306, 374–375
Moore, P., 139
Moreau, D., 66
Morlock, L., 300
Morris, A. S., 7
Morris, J., 361, 364
Morris, T. L., 133
Morrison, M., 105, 106
Morten, G., 69
Moseley, S., 181
Mostert, M. P., 372, 375
Moustakas, C., 92
Mufson, L., 66, 67, 71, 77, 78
Mulhern, R. K., 386
Mullins, J. L., 363
Mulvey, E. P., 41
Mundy, P., 364
Muris, P., 119

Murphy, J. J., xii, 279, 281, 282, 285, 286, 287, 290, 294, 298, 299, 300, 306
Murphy, L., 254
Muskat, B., 374
Myers, L., 253
Myers, S. M., 359
Myles, B. S., 362, 363

Naar-King, S., 341
Nassar-McMillan, S., 82
Neenan, M., 163, 178
Neimeyer, R., 159
Nelson, 193
Nelson, J. M., 372
Nelson, T., 305
Nelson, T. S., 331
Ness, M. E., 290
Newsome, S., 306
Nezu, A. M., 155, 181
Ngo, V, 135
Nielsen, S., 156
Noll, J. O., 43
Norcross, J. C., 174, 181, 192, 282
North, J., 264
Northey, W. F., 340, 342
Nounopolous, A., 361
Nuffield, E. J., 4
Nunnally, E., 282
Nylund, D., 326

Oakland, T., 63
Oaklander, V., 93
Obasi, E. M., 79
O'Brien, R. M., 192, 194, 197
Ochoa, S. H., 40
O'Connor, K., 93
Oei, T. P. S., 192, 195, 197
Offord, D. R., 131
Ogborne, A., 131
Ogden, T., 341
O'Hanlon, W. H., 281, 326
Ojiambo, D., 104, 106
Olson, K., 322
Olsson, M., 341
Omizo, M., 258
Orlinsky, D. E., 282
Ortiz, S. O., 40
Oswald, D. P., 360
Owens, M., 129
Ozabaci, N., 139

Packman, J., 104, 106
Pacquiao, D. F., 81
Pakaslahti, L., 137
Panayotov, P. A., 282
Paniagua, F. A., 65, 76, 80
Parrett, J., 363
Parsons, B., 340
Parsons, B. V., 340
Passaro, P. D., 262
Pastor, R., 376
Pate, R. H., 37
Patterson, G. R., 341
Paul, G. L., 339
Paulson, B. L., 288
Pearlman, S. F., 322
Peaster, L. G., 372
Pedersen, P. B., 66
Pepitone-Arreola-Rockwell, F., 40
Pepper, R., 233
Perry, B., 91, 105
Peterson, D., 157
Peterson, S., 328
Peterson, T. R., 341
Petra, J. R., 261
Pettorini, D., 157
Piacentini, J., 129
Piacentini, J. C., 139
Piaget, J., 168, 181, 335
Pianta, R. C., 300
Pichette, E. F., 80
Pinderhughes, E. B., 322
Pinquart, M., 385
Pinsof, W., 339
Plaisted, K. C., 360
Poland, S., 41, 42
Polder, S. K., 192, 195
Pollack Dorta, K., 66
Ponterotto, J. G., 66
Pope, L. K., 171
Poppen, W., 257
Popper, K., 159
Post, M., 306
Powell, N. R., 137
Powlitch, S., 368
Prata, G., 331
Prochaska, J. O., 174
Prout, H. T., ix, 1, 19, 25, 287, 367, 368, 370
Prout, S. M., xii, 25
Prouty, A., xii
Prouty, A. M., 317, 322, 323
Purswall, K., 91

Quinn, B., 256

Rachin, R., 253
Radtke, L., 254
Randall, J., 13
Randolph, D., 256
Rapee, R., 359
Rapee, R. M., 128, 131
Rapin, I., 359
Rapoport, J. L., 129
Rappaport, J. L., 137
Rappen, U., 92
Rasbury, W. C., 34
Rathus, S. A., 335
Ray, D., 91, 93, 95, 97, 98, 99, 103, 104, 106
Rayner, R., 117
Reaven, J., 362, 364
Reese, R. J., 19
Reid, J., 341
Reid, J. B., 341
Reinecke, M. A., 136
Reis, B. F., 342
Reiss, D., 337
Reiter, M., 329
Remley, T. B., 35
Repp, A. C., 54
Reschly, D. J., 32
Resick, P. A., 134
Retter, K., 262
Reynolds, C. R., 50
Reynolds, S., 368
Reynolds, W. M., 127, 366
Rhine, T., 91
Rhodes, R. L., 40
Ricard, R., 298
Richardson, T., 136
Ridley, C., 157
Ridley, C. R., 157
Rieckmann, T. R., 80
Risser, H. J., 190
Ritter, B., 117
Rivers, I., 74
Robert, M., 253
Roberts, E., 119
Roberts, J., 331
Robertson, J., xii, 317
Robin, M., 156
Rochat, P., 125
Rockymore, M., 79
Roeden, J. M., 370
Rogers, C., 91, 92, 93, 94, 95, 96, 102, 174
Rollnick, 182
Ronan, K. R., 13
Rønnestad, M. H., 282
Rorer, L., 169
Rosario, A. C., 256
Rosenblatt, P. C., 322
Rosenthal, D. M., 331
Rosman, B., 340
Ross, A. O., 26, 36
Rossiter, L., 385–386
Rowe, C., 342
Rowland, M. D., 13, 341
Rowland, M. R., 341
Roy, J., 126
Rubin, A., 298

Rubin, E., 361
Ruble, L., 359, 361, 364
Ruble, L. A., xii, 357, 362
Rudolf, M., 298
Ruggiero, G. M., 159
Ruiz, A. S., 69
Russell, G. F. M., 340
Ryan, 103
Ryan, V., 91, 93, 97, 98, 102, 103, 105

Sadoff, R. L., 50
Sage, R. M., 119
St. George, S., 331
Saldana, L., 341
Saleebey, D., 281
Sales, B., 49
Salkovskis, P. M., 129
Sandy, J. M., 73
Santisteban, D. A., 340
Santos, A. J., 137
Sapp, M., 198, 254
Sassaroli, S., 159
Saunders, 193
Saunders, L., 372
Sawalani, G. M., 137
Sawins, M., 337
Scamardo, M., 306, 374–375
Schaefer, C., 91, 93
Schaeffer, C. M., 341
Schechtaman, Z., 373, 376
Scheeringa, M. S., 134
Scherer, D. G., 288, 341
Schlossburg, M. C., 139, 140
Schneider, S., 380
Schnicke, M. C., 134
Schnur, J., 171
Schoenwald, S. K., 13, 341
Schopler, E., 359, 363
Schottelkorb, A., 106
Schrier, C. J., 51
Schultz, R. T., 360
Schwartz, R. C., 327, 328, 335, 336
Schwartz, S., 340
Scott, C. V., 139
Sebold, J., 282
Selekman, M., 282, 302, 306
Seligman, M. E. P., 117, 163
Sellers, R. M., 73
Selvini-Palazzoli, M., 331
Semrud-Clikeman, M., 374
Serovich, J., 322
Shadish, W. R., 339
Shah, I., 307
Shaknai, J., 362
Sharpe, D., 385–386
Sharry, J., 298
Shaw, C. M., 79
Shea, V., 359
Shearn, D., 256
Sheeley, V. L., 44
Sheely-Moore, A., 106
Sheidow, A. J., 341
Shen, Y., 104, 385
Shepherd, J. N., 50
Sherman, D. K., 119
Sherwood, V., 175
Shibusawa, T., 321
Shilts, L., 282, 300, 301
Shimokawa, K., 294
Shirk, S. R., 125, 288
Shwery, 193
Siegel, D., 105
Siegel, L. J., 34
Sigman, M., 139
Silverman, M. S., 192, 195, 196
Silverman, W., 106
Silverman, W. K., 340
Silverstein, O., 322
Silvestre, A. J., 74
Simic, M., 340
Simmonds, D. W., 36
Simon, J., 305
Simpson, R., 363
Singer, G. H. S., 383
Singh, N. N., 54
Sinha, J. W., 73
Siqueland, L., 342
Sites, E. W., 74
Skinner, B. F., 117
Sklare, G. B., 281
Skull, J., 371, 372
Slaby, R. G., 138
Slesnick, N., 341
Slifer, K. J., 382
Slovenko, R., 50
Smetana, J. G., 7
Smith, C., 326
Smith, C. A., 171
Smith, D., 27, 28, 31, 38, 39
Smith, J. B., 288
Smith, L. A., 341
Smith, M. L., 18, 19, 192
Smith, P., 134
Smith, R., 298
Smith, S. R., 54
Sniscak, C. C., 103
Sofronoff, K., 364
Sorenson, G. P., 43, 45, 48, 52, 54
Sparks, J., 21
Spence, S. H., 131, 132
Sperry, L., 117
Spirito, A., 387, 388
Sprenkle, D., 339, 340
Springer, D. W., 298
Spurlock, J., 70
Stallard, P., 125, 136
Stambaugh, L. F., 341
Stams, G. J. J. M., 305
Stanton, M. D., 339
Stark, K. D., 127
Steege, M. W., 53
Stein, B. D., 135
Stein, M. B., 131
Stein, M. T., 131
Stein, R., 341
Steinberg, L., 7
Steiner, T., 287
Steinglass, P., 337
Stone, C., 37
Stone, W. L., 361
Stone-Fish, L., 332
Storey, K., 306
Strahilov, B. E., 282
Streeter, C. L., 306
Streiner, D. L., 360
Strong, T., 331
Strosahl, K. D., 115, 173
Stucky, B. D., 137
Stuhlman, M. W., 300
Stulmaker, H., 106
Sturmey, P., 368, 369
Sue, D., 62, 63, 64, 65, 69, 75, 78, 79, 80
Sue, D. W., 63, 64, 65, 69, 75, 78, 79
Sukhodolsky, D. G., 139
Sullivan, J., 106
Surratt, A. V., 363
Suzuki, L. A., 66
Sweeney, D. S., 103, 104
Sweezy, M., 328, 335
Sywulak, A. E., 103
Szabo, P., 282
Szalavitz, M., 91, 105
Szapocznik, J., 340
Szatman, P., 360

Tafrate, R. C., 162
Tager-Flusberg, H., 360
Tamasese, K., 322
Tamborella, E., 259
Tangeman, J. A., 255
Tanguay, P., 364
Tankersley, M., 363
Tantam, D., 360
Tatum, D., 75
Taylor, S. E., 119, 283
Teasdale, J. D., 117
Tebbenkamp, K., 362
Teeters, A., 134
Terjesen, M., 155, 170, 187
Terlonge, C., 367
Teubert, D., 385
Thase, M. E., 115, 120

Thienemann, M., 139
Thomas, M., 328
Thomas, T., 137
Thompson, C., 262
Thompson, W., 288
Thorne, J., 258
Tiba, A., 190
Tien, L., 322
Todd, T. C., 339
Tolan, J., 94
Tolan, P. H., 4, 5
Toland, M., 359
Tomm, K., 331
Tompkins, K., 139
Toste, J. R., 119
Tramontana, M. G., 18
Trepper, T. S., 282, 287, 289
Trexler, L. D., 192, 193
Trip, S., 187, 195, 197
Tripodi, S. J., 306
Tsai, M., 106
Tubbs,C. Y., 322
Tuchman, R., 359
Turner, C. W., 340, 341
Turner, R., 342
Turner, S., 129
Tyc, V. L., 386

Uken, A., 282
Unger, J. B., 68

Valeri, S. M., 142
Van Ameringen, M., 131
VandeCreek, L., 50
Van de Hout, W. J., 196–197
Van der Sleen, J., 196
VanFleet, R., 103
van Hecke, A. V., 364
Vansoyoc, S. L., 20
Varhely, K., 288
Vasquez, M. T., 192
Vaughn, B. E., 137
Velleman, S., 136
Vernon, A., 170, 181, 183, 186, 187, 195, 197
Vervaeke, S., 372
Vetere, A., 326
Vierling, L., 49, 50
Volkmar, F. R., 360

Wachtel, P. L., 279
Wade, S. L., 377, 382, 383
Wadsworth, B. J., 6
Wadsworth, M. E., 80
Waldo, S. L., 41
Waldron, H., 340
Waldron, H. B., 341
Walz, N. C., 377
Wampold, B. E., 288
Warburton, J., 340
Ward, A. B., 381
Ward, D. M., 341
Wark, L., 328
Warschausky, S., 381, 383
Waters, V., 184
Watkins, N. L., 79
Watson, J. B., 117
Watzlawick, P., 280, 323, 324, 331
Weakland, J., 280, 323
Webb, C. A., 136
Webb, E., 334
Webb-Ferebee, K., 103
Weems, C. F., 134
Weigel Foy, C., 322
Weiner-Davis, M., 281, 282, 290, 305, 326
Weiss, B., 197
Weissman, M. M., 66
Weisz, J. R., 3, 18, 19, 20, 142, 188, 197
Welch, R., 257
Welfel, E. R., 35
Wells, K. C., 340
Wells, M. G., 21
Wessel, I., 196–197
West, J., 91
Westermark, P. K., 341
Wheeler, J., 282
Whidby, J. M., 137
White, H., 129
White, J. R., 141
White, M., 326
Whiting, R. A., 331
Wicker, C. W., 261
Wiener, J., 374, 376
Wiest, J., 262
Wilde, 184
Wilkins, P., 95
Williams, T. I., 129
Willis, H., 362
Willoughby, T., 372
Wills, T. A., 73
Willutzki, U., 282
Wilson, F. J., 360
Wilson, K., 91, 97, 98, 102
Wilson, K. G., 115, 173
Wing, L., 359
Winkler, A. M., 371, 372
Winkler, R. C., 54
Winnett, R. A., 54
Winnicott, D. W., 92
Winslade, J., 338
Witt, J. C., 50
Wittman, W. D., 43
Wolfe, J., 181
Wolin, S., 296
Wolpe, J., 117, 162
Wong, E., 262
Wood, J. J., 139, 140
Woods, P. J., 192, 194, 197
Wright, J. H., 115, 120
Wubbolding, R., 235, 236, 240, 253
Wulff, D., 331

Yaeger, A. M., 73
Yarbrough, J., 262
Yarnish, P., 258
Yell, M. L., 54
Yevisker, M., 382
Young, A., 129

Zajonc, R. B., 168
Zeeman, R., 255
Zein, F., 361
Zettle, R., 192, 195
Zirkelback, E. A., 19
Ziskind, E. L., 328, 335
Zorn, R., 253
Zucker, S., 300
Zunin, L., 226, 252, 254

Subject Index

Abuse. *See* Child abuse; Substance abuse
Acceptance and commitment therapy, 115
Ackerman, Nathan, 318
ADHD. *See* Attention deficit hyperactivity disorder
Adolescents. *See* Children and adolescents
African Americans, 68, 69, 76, 78–79, 106
Age:
  age of consent for treatment, 50
  developmental issues related to (*see* Developmental issues)
  traumatic brain injury variance by, 377
Aggression, 137–139, 379. *See also* Behavioral and conduct disorders; Violence
Albert Ellis Institute, 158, 186, 205–206
Alcohol use. *See* Substance abuse
American Academy of Child and Adolescent Psychiatry (AACAP), 366, 367, 370, 372, 373, 375
American Association of Marriage and Family Therapy (AAMFT), 319
American Counseling Association (ACA), 40, 62
American Family Therapy Academy (AFTA), 320
American Indians/Alaskan Natives, 79–80
American Orthopsychiatric Association, 2
American Psychological Association:
  code of ethics of, 28–29, 31, 37–39, 40–41, 50, 53
  intellectual disabilities statistics of, 365
  multicultural standards of practice, 62
  resolution on effectiveness of psychotherapy, 192
American School Counselor Association, 33, 40–41, 53
Antisocial behavior, 4, 13. *See also* Behavioral and conduct disorders
Anxiety and anxiety disorders:
  child-centered play therapy addressing, 97
  cognitive-behavioral and behavioral approaches to, 119, 123, 124, 127–129, 131–134, 136–137, 140, 141–142, 364, 369–370, 376
  comorbid conditions with, 131, 134, 360, 363, 364, 366, 369–370, 374, 376, 379–380, 387
  familial, 381, 383, 386, 388
  family therapy/systemic approaches to, 340, 342
  irrational beliefs resulting in, 171, 172, 173
  prevalence of, 5
  rational emotive behavior therapy for, 191, 196, 197, 201, 205
  reality therapy approaches to, 224
  research on, 17
  school phobia as, 17, 133–134
  social phobia as, 17, 131–134, 191, 197
  solutions-focused approaches to, 298, 299–300, 374
Arab and Muslim Americans, 82
Asian Americans/Pacific Islanders, 68, 74, 80–81, 82–85, 106–108
Assessment and diagnosis:
  BASIC ID/BASIC IDEAL approaches to, 12
  cognitive-behavioral and behavioral approaches including, 124, 143–144, 147
  culturally responsive interpersonal therapy including, 67–71, 83–84
  developmental considerations in, 6
  Diagnostic and Statistical Manual of Mental Disorders use for, 25, 143, 358, 365, 372
  disability-related interventions including, 83, 358, 360–361, 365, 372
  family therapy/systemic approaches including, 344
  functional behavioral assessments as, 360–361
  instruments for (*see* Assessment instruments)
  rational emotive behavior therapy including, 188–189
  solution-focused approaches to, 285–286
Assessment instruments:
  Acculturation, Habits, and Interests, Multicultural Scale for Adolescents (AHIMSA), 68
  Behavioral Academic Self-Esteem Rating Scale, 260
  Behavior Assessment System for Children (BASC), 261
  Child-Rearing Practices Questionnaire, 258
  Coopersmith Self-Esteem Inventory, 260
  Jones Intentional Multicultural Interview Schedule (JIMIS), 70
  Likert scale, 262–263
  Menstrual Distress Questionnaire (MDQ), 261
  Nowicki-Strickland Internal-External Scale, 256
  Nowicki-Strickland Locus of Control Scale for Children, 258, 259
  Outcome Questionnaires (OQ), 21
  Outcome Rating Scale (ORS), 21
  Piers-Harris Children's Self-Concept Scale, 261
  Reynolds Adolescent Depression Scale, second edition (RADS-2), 366
  Subjective Units of Distress Scale (SUDS), 124, 162
Association for Multicultural Counseling and Development, 62
Association of Family Therapy and Systemic Practice, 320

Attachment-based family therapy, 342
Attention deficit hyperactivity disorder (ADHD):
child-centered play therapy addressing, 97
cognitive-behavioral and behavioral approaches to, 141, 376
comorbid conditions with, 372, 374, 376, 379
medication for, 51
mindfulness training for, 376
prevalence of, 5
solution-focused approaches to, 374
Autism spectrum disorders:
assessment of, 358, 360–361
behaviors and abilities impacted by, 359, 360–361
children/adolescents with disabilities with, 5, 358–365, 389–390
cognitive theories on/approaches to, 358–359, 359–360, 362–365
comorbid conditions with, 359, 360–361, 363, 364
core symptoms treatment for, 362–364
familial and parent issues with, 362, 364–365
prevalence of, 5
resources on, 389–390
therapeutic approaches to, 361–364
Axline, Virginia, 2–3, 92, 93

BASIC ID/BASIC IDEAL approaches, 12
Behavioral and conduct disorders. *See also* Attention deficit hyperactivity disorder
aggression as, 137–139, 379
antisocial behavior in, 4, 13
child-centered play therapy addressing, 95, 97, 99, 104, 106
cognitive-behavioral and behavioral approaches to, 119, 137–139, 382
comorbid conditions with, 360–361, 366, 368, 372, 373, 379, 382, 385
delinquent behavior in, 4, 13, 17, 217–218, 242, 253–254, 258–259, 340–341
family structure impacting, 321
family therapy/systemic approaches to, 13, 340–341, 343–346
group therapy challenges with, 185, 242
multisystemic therapy for, 13, 341
parent training for, 368
prevalence of, 4, 5
rational emotive behavior therapy for, 185, 188–190, 196, 198
reality therapy approaches to, 217–218, 225, 229, 242, 244–250, 253–254, 258–263
research on, 17
solutions-focused approaches to, 298, 301, 306, 307–309
Behavioral approaches. *See* Cognitive-behavioral and behavioral approaches
Bellah v. Greenson (1978), 46
Benskin v. Taft City School District (1980), 51
Berg, Insoo Kim, 280
Bertanlanffy, Ludwig von, 318
Bibliotherapy, 239–240
Binet, Alfred, 2
Bipolar disorder, 360
Bisexuals, 74
Brief Family Therapy Center (BFTC), 280, 281, 304
Brief therapy:
brief strategic family therapy as, 340
child-centered play therapy as, 104–105
solution-focused brief therapy as, 280–281, 305–306, 333, 370, 374–375

California Association of Marriage and Family Therapists, 320
Case studies, by name:
Amara, 82–85
Jack, 245–250
John, 266–271
Julian, 297
Julie, 143–147
Lily, 291–292
Little Hans, 2
Maria and parents, 307–309
Marisa, 297–298
Mia, 106–108
Michele M., 200–205
Susan, 343–346
Case studies, by topic:
child-centered play therapy, 106–108
cognitive-behavioral and behavioral approaches, 143–147
culturally responsive interpersonal therapy, 82–85
family therapy/systemic approaches, 343–346
rational emotive behavior therapy, 200–205
reality therapy approaches, 219, 245–250, 266–271
solution-focused approaches, 291–292, 297–298, 299–300, 307–309
CBT. *See* Cognitive-behavioral and behavioral approaches
Centers for Disease Control and Prevention (CDC), 5
Child abuse:
cognitive-behavioral and behavioral approaches to trauma from, 143–147
ethical issues related to, 32, 37–38
legal issues related to, 48–49, 52
solution-focused approaches to, 282
traumatic brain injury from, 377
Child/adolescent counseling and psychotherapy:
adolescent-specific issues in, 7, 10–12
assessment for (*see* Assessment and diagnosis)
case studies of (*see* Case studies, by name; Case studies, by topic)
child-centered play therapy as, 2–3, 91–109
child parent relationship therapy as, 93, 105, 106
child teacher relationship therapy as, 105, 106
chronic need for, 3–5
cognitive-behavioral and behavioral approaches as (*see* Cognitive-behavioral and behavioral approaches)

community-based treatment as, 3
confidentiality of, 28–29, 35, 37–39, 43–49, 52–53, 54
cultural issues considered in (*see* Cultural issues)
culturally responsive interpersonal therapy as, 61–86
development issues considered in (*see* Developmental issues)
disability-related issues impacting, 3, 5, 32, 44, 53, 54, 83, 196, 200, 298, 299, 306, 357–389 (*see also* Medical health issues)
efficacy of, 14–20, 142–143, 192–199, 253–265, 304–307, 339–342
environmental influences considered in, 9–10
ethical issues for (*see* Ethical issues)
evidence-based treatments as, 3, 20–21, 53–54, 61, 97–98, 128
family therapy as (*see* Family therapy)
filial therapy as, 93, 97–98, 102–103, 105, 108
goal setting in (*see* Goal setting)
group therapy as (*see* Group therapy)
historical perspectives on, 2–3 *(see also under specific treatments)*
legal issues for, 26–27, 28, 36, 38, 42–55
mental health issues leading to (*see* Mental health issues)
motivation for, 7–8
multimodal and multisystemic approaches to, 12–14, 341 (*see also* Systemic approaches)
multisystemic therapy as, 13–14, 341
overview of, 1, 21–22
personality considered in, 6, 10, 91–92, 115–116, 327–328, 335–336
play therapy as, 2–3, 91–109, 334–335
professionals providing (*see* Therapists and counselors)
psychoanalysis as, 2, 91–92, 116–117, 318
rational emotive behavior therapy as, 115, 155–205
reality therapy as, 115, 217–271
research on, 14–20
school-based interventions as (*see* School-based interventions)
solution-focused approaches as, 279–310, 326, 332–333, 370, 374–375
unique aspects of, 7–12
vision for future, 5
Child-centered play therapy (CCPT):
adolescent application of, 102
basic assumptions of, 93–94
brief version of, 104–105
case study of, 106–108
clinical applications of, 98–105
congruence focus in, 96
culture considered in, 99, 106
educational applications of, 105–106
empathic understanding in, 96–97
empirical support for, 97–98
family and parent participation in, 93, 103, 104–105, 108
goals and process of change in, 95–97, 103
group setting for, 92, 102, 103–104
guiding principles of, 99
history and status of, 2–3, 91–93
limit setting in, 101–102
overview of, 91, 109
parenting applications of, 105
psychological maladjustment leading to, 94–95
setting and materials for, 99
theory/philosophy underlying, 93–97
therapeutic relationships in, 95–97, 99, 101, 109
therapeutic skills needed for, 99–102
unconditional positive regard in, 96
very-young child application of, 102–103
Child parent relationship therapy (CPRT), 93, 105, 106
Children and adolescents:
abuse or maltreatment of, 32, 37–38, 48–49, 52, 143–147, 282, 377
counseling for (*see* Child/adolescent counseling and psychotherapy)
cultural issues among (*see* Cultural issues)
developmental issues for (*see* Developmental issues)
with disabilities (*see* Disabilities, children and adolescents with)
families of (*see* Families and parents)
informed consent of, 28, 35, 49–51
mental health issues among (*see* Mental health issues)
personalities of (*see* Personality)
Child teacher relationship therapy (CTRT), 105, 106
Choice theory, 220, 223–224, 236–240, 263–264
Circularity, 325–326
Cognitive-behavioral and behavioral approaches:
acceptance and commitment therapy as, 115
adolescent applications of, 135–139
affective education in, 123
to aggression, 137–139
to anxiety and anxiety disorders, 119, 123, 124, 127–129, 131–134, 136–137, 140, 141–142, 364, 369–370, 376
assessment in, 124, 143–144, 147
to attention deficit hyperactivity disorder, 141, 376
to autism spectrum disorders, 358–359, 359–360, 362–365
basic theory and assumptions of, 118–119
to behavioral and conduct disorders, 119, 137–139, 382
case study of, 143–147
child applications of, 124–135
cognitive picture rehearsal as, 363
cognitive processing therapy as, 144–147
cognitive restructuring therapies as, 120, 122, 126, 127, 130, 133, 134, 136, 138, 140
communication facilitation in, 140, 146
computerized, 136–137
contingent reinforcement in, 128, 140, 387
Coping Cat program as, 127–128
coping skills therapies in, 120, 123, 126, 127–129, 133, 135, 387

Cognitive-behavioral and behavioral approaches (*continued*)
to depression and depressive disorders, 118, 119, 125, 126–127, 135–137, 140, 141, 143–147, 364, 374, 376
developmental considerations in, 118, 124–126, 135, 140
dialectic behavior therapy as, 115
disability-related interventions as, 53, 358–359, 359–360, 362–365, 367–370, 374, 375–376, 380, 382, 386–388
to eating disorders, 141, 142
efficacy of, 142–143
evidence-based, 53–54, 128
exposure therapy or imagery in, 124, 128, 130, 131–132, 133, 134, 135, 136, 140
family and parent participation in, 125, 128–131, 132, 133, 134, 139–140, 142, 143–144, 145, 146–147, 362, 364–365, 388
family interventions in, 130–131, 139–140, 388
feedback in, 121
generalization in, 121, 362, 375
goal setting in, 54, 121
group setting for, 129, 135, 141–142
history and status of, 3, 116–118
homework assignments in, 121, 126, 128, 130, 133, 138, 141, 145, 362, 374
to intellectual disabilities, 367–370
to learning disabilities, 374, 375–376
mindfulness training in, 123, 376
normalization in, 130
to obsessive-compulsive disorder, 124, 129–131, 364
overview of, 115–116
parent counseling and skills training as, 141, 142, 364–365, 375
person-centered approaches as, 115
to posttraumatic stress disorder, 124, 134–135, 140, 141, 143–147
problem solving therapies in, 120, 122, 126, 127, 132, 136, 138, 145, 387
psychoeducation in, 123, 127, 129–130, 131, 133, 134, 136, 140, 145, 364–365
rational emotive behavior therapy as, 115, 155
reality therapy as, 115
relapse prevention in, 121, 128
relaxation training in, 123, 126, 128, 132, 134, 363, 386–387
role playing and modeling in, 122, 123, 124, 126, 128, 133, 138, 141, 362
safety planning in, 135
school-based interventions using, 53–54, 141
self-instructional training as, 115
self-monitoring in, 122–123, 127
self-regulation/self-management in, 123, 127, 363
to social phobia, 131–134
social skills training in, 132, 138, 141, 362, 375, 376
Socratic questioning in, 121
somatic management skills in, 127, 136
techniques used in, 120–124
theory underlying, 118–120, 359–360
trauma-focused, 134–135, 140, 143–147
to traumatic brain injuries, 380, 382
view of psychopathology in, 119–120
visual supports or cuing in, 362–363, 364
Collaborative Family Healthcare Association, 319
Collectivist orientation, 64, 66, 67, 73, 79, 80–81, 82
Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), 319
Communication:
cognitive-behavioral and behavioral approaches to, 140, 146
communication analysis, 73–76
cultural influences and interpretations of, 40–41, 72–76
language for, 9, 40–41, 75
nonverbal, 75, 100
solution-focused approach importance of, 281, 283–284
traumatic brain injuries impacting, 378–379
Community mental health movement, 3
Computer-based issues. *See* Internet- or computer-based issues
Conduct disorders. *See* Behavioral and conduct disorders
Contingent reinforcement, 128, 140, 387
Control theory, 219–220, 222–223
Coping skills:
cognitive-behavioral and behavioral approaches to, 120, 123, 126, 127–129, 133, 135, 387
Coping Cat program including, 127–128
rational emotive behavior therapy approach to, 177–178, 202–205
solution-focused coping questions on, 295
Counseling. *See* Child/adolescent counseling and psychotherapy
Counselors. *See* Therapists and counselors
Cultural issues. *See also specific minority groups*
acculturation as, 67–68, 70–71, 72, 80, 81–82, 84
child-centered play therapy consideration of, 99, 106
counselor cultural competence with, 30, 62–66
cultural literacy building about, 65–66
culturally responsive interpersonal therapy addressing, 61–86
definitions related to, 63–64
demographics reflecting, 61
discrimination and prejudice based on, 74, 79, 81–82
ethical issues related to, 30, 40–41, 62–66
gender roles as, 72
intersectionality of identities as, 322–323
language as, 40–41, 75
racial/cultural/ethnic identity as, 68–70, 72, 74, 79, 81, 82, 84, 322–323
religion and spirituality as, 78–79, 82, 156–157
sexual identity as, 72, 74
socioeconomics as, 75, 106

stereotyping based on, 65
systemic approaches/family therapy consideration of, 322–323, 326
Culturally responsive interpersonal therapy (CR-IPTa):
acculturation considered in, 67–68, 70–71, 72, 80, 81–82, 84
case study of, 82–85
child/adolescent applications of, 66–67
collectivist orientation in, 64, 66, 67, 73, 79, 80–81, 82
communication analysis in, 73–76
contracting for focus on treatment in, 70–71
counselor self-awareness in, 65
cultural context identification in, 67–68, 83–84
cultural literacy building in, 65–66
culture, defined for, 63
demographics necessitating, 61
diagnostic formulation and education in, 67–71, 83–84
ethnic identity issues in, 68–70, 72, 74, 79, 81, 82, 84
facilitated problem solving in, 71–76
families and parents in, 71–72, 84
Jones Intentional Multicultural Interview Schedule use in, 70
multicultural, defined for, 63
multicultural clinical skill application in, 66
multicultural competence, defined for, 63–64
multicultural standards of practice, 62–66
overview of, 61
religion and spirituality considered in, 78–79, 82
resources on, 85–86
role playing alternative interactions in, 76
sense-making in social interactions in, 72–73
sexual identity issues in, 72, 74
specific population strengths and challenges in, 78–82
termination of, 76–78, 85
therapeutic relationships in, 64–66
treatment process in, 67–78, 84

Delinquent behavior:
family therapy/systemic approaches to, 13, 340–341
multisystemic therapy for, 13, 341
prevalence of, 4
reality therapy approaches to, 217–218, 242, 253–254, 258–259
research on, 17
Depression and depressive disorders:
child-centered play therapy addressing, 97
cognitive-behavioral and behavioral approaches to, 118, 119, 125, 126–127, 135–137, 140, 141, 143–147, 364, 374, 376
comorbid conditions with, 131, 134, 135, 360, 364, 366, 372, 374, 376, 379–380, 385, 387
familial, 381, 383, 386, 388
family structure impacting, 321
family therapy/systemic approaches to, 317, 340, 342
irrational beliefs resulting in, 171, 172, 173
medication for, 126
prevalence of, 5
rational emotive behavior therapy for, 196, 201, 204
reality therapy approaches to, 224–225, 229
suicide attempts and ideation related to, 135–136
de Shazer, Steve, 280
Developmental issues:
adolescent-specific, 7
child/adolescent counseling consideration of, 5–7, 9, 10
child-centered play therapy consideration of, 91, 92, 102–103, 104
cognitive-behavioral and behavioral approaches consideration of, 118, 124–126, 135, 140
family development as, 321–322
family therapy consideration of, 321–322, 335–336
personality development as, 6, 10
Piaget's theory of, 6–7, 125
rational emotive behavior therapy consideration of, 181, 184–185
reality therapy consideration of, 242, 262
research impacted by, 16
solution-focused approach consideration of, 287
verbal/language ability as, 9
Diagnosis. *See* Assessment and diagnosis
Diagnostic and Statistical Manual of Mental Disorders (DSM), 25, 143, 358, 365, 372
Dialectic behavior therapy, 115
Directive family play therapy, 334–335
Disabilities, children and adolescents with:
assessment of, 83, 358, 360–361, 365, 372
autism spectrum disorders in, 5, 358–365, 389–390
cognitive-behavioral and behavioral approaches for, 53, 358–359, 359–360, 362–365, 367–370, 374, 375–376, 380, 382, 386–388
collaboration of professionals working with, 357–358, 370
comorbid conditions among, 359, 360–361, 363, 364, 366–367, 368–370, 372, 373–374, 376, 379–380, 382, 385, 387
coping skills therapies for, 387
evidence-based interventions for, 53
familial and parental involvement with, 358, 362, 364–365, 380, 381, 382–383, 385–386, 388–389
family therapy for, 380, 382–383, 388–389
general considerations with, 357–358
group counseling for, 374, 376, 388–389
humanistic psychotherapy for, 376
Individuals with Disabilities Education Improvement Act for, 3, 32, 44, 53, 54, 365, 372, 384
intellectual and developmental disabilities in, 298, 306, 359, 365–371, 390
intervention implications for, 357–389
learning disabilities in, 53, 83, 196, 200, 371–377, 385, 390
medication for, 370
mindfulness training for, 376
overview of issues for, 357, 389

Disabilities, children and adolescents with (*continued*)
parent counseling/training for parents of, 358, 364–365, 368, 375, 382–383
physical disabilities in, 384–389, 391 (*see also* Medical health issues)
problem solving training for, 387
progress monitoring of, 370–371, 376
relaxation training for, 386–387
resources on, 389–391
school-based interventions for, 53, 83, 200, 299, 357, 365, 371–377, 379, 380–381
social skills training for, 362, 375, 376, 383
solution-focused approaches for, 298, 306, 370, 374–375
therapeutic modifications to accommodate, 358, 364, 367, 370, 373–374, 376
traumatic brain injury in, 377–383, 390–391
Discipline, 233–234, 245–250
Domestic violence, 282. *See also* Child abuse
Drug use. *See* Medication; Substance abuse
Duty to inform, 46–47
Duty to warn, 45–46, 47–49

Eating disorders:
cognitive-behavioral and behavioral approaches to, 141, 142
confidentiality of treatment for, 46
family structure impacting, 321
family therapy/systemic approaches to, 340
rational emotive behavior therapy for, 196
Education and training:
in family therapy/systemic approaches, 319–320
psychoeducational (*see* Psychoeducation)
in rational emotive behavior therapy, 158
in reality therapy approaches, 218, 220, 261, 263
skills training as (*see* Coping skills; Mindfulness training; Parent counseling and skills training; Problem solving; Relaxation training; Social skills training; Stress management)
of therapists and counselors, 29–30, 39, 158, 218, 220, 261, 263, 319–320
Educator Training Center, 218
Efficacy of treatments. *See also* Evidence-based treatments
of cognitive-behavioral and behavioral approaches, 142–143
of family therapy/systemic approaches, 339–342
of rational emotive behavior therapy, 192–199
of reality therapy approaches, 253–265
research on, 14–20
of solution-focused approaches, 304–307
Eisel v. Board of Education (1991), 47
Electronic issues. *See* Internet- or computer-based issues
Ellis, Albert, 155, 156–158
Albert Ellis Institute, 158, 186, 205–206
Empathic understanding, 96–97
Environmental influences, 9–10. *See also* Cultural issues
Erickson, Milton, 280

Ethical issues:
child abuse reporting as, 32, 37–38
child and parental rights as, 35–37
client identification as, 28, 33–35
codes of ethics on, 26–29, 31–33, 37–39, 40–41, 50, 53
competence as, 29–30, 39
confidentiality as, 28–29, 35, 37–39, 48
conflicts of interest as, 27
cultural sensitivity and competence as, 30, 40–41, 62–66
informed consent as, 28, 32–33, 34, 35, 41–42, 50
interpreter usage as, 40–41
legal issue distinction from, 26–27, 28, 42, 48, 50, 55
medication use as, 42
multiple relationships as, 31
overview of importance of, 25–26, 55
parental role/consent as, 28, 32–33, 34, 35–37, 41–42
private practice creating, 30–31
professional relationships as, 29
public statements and presentations as, 30
recent issues highlighting, 40–42
responsibility and client welfare as, 27–28
school-based interventions facing, 29–42, 53–54
school violence creating, 41
second opinions as, 39
sexuality-related issues as, 42
suicide attempts and ideation creating, 41–42
violations of, 31–32
European Brief Therapy Association (EBTA), 281
Evidence-based treatments. *See also* Efficacy of treatments
child-centered play therapy as, 97–98
cognitive-behavioral and behavioral approaches as, 53–54, 128
empirically supported treatments as, 20–21
historical perspectives on, 3
interpersonal therapy as, 61
practice-based evidence for, 21
resources on, 20, 21
school-based interventions using, 53
Ewing v. Goldstein (2004), 46–47
Exposure therapy:
cognitive-behavioral and behavioral approaches to, 124, 128, 130, 131–132, 133, 134, 135, 136, 140
rational emotive behavior therapy including, 197

Families and parents:
anxiety and depression in, 381, 383, 386, 388
belief systems of, 324–326, 331–334, 346
child-centered play therapy participation of, 93, 103, 104–105, 108
children of (*see* Children and adolescents)
circularity of behavior in, 325–326
cognitive-behavioral and behavioral approaches including, 125, 128–131, 132, 133, 134, 139–140, 142, 143–144, 145, 146–147, 362, 364–365, 388
cultural issues among (*see* Cultural issues)

culturally responsive interpersonal therapy participation by, 71–72, 84
disability-related interventions involving, 358, 362, 364–365, 380, 381, 382–383, 385–386, 388–389
ethical issues involving, 28, 32–33, 34, 35–37, 41–42
family development and life cycle, 321–322
family myths in, 190
family therapy for (*see* Family therapy)
informed consent of, 28, 32–33, 34, 35, 41–42, 49–51
interactional patterns in, 323–324, 325, 330–331
legal rights and responsibilities of, 36, 44, 49–52
parent counseling for (*see* Parent counseling and skills training)
rational emotive behavior therapy involvement of, 187–191, 198, 200, 202, 204–205
reality therapy involving, 250–253, 257–258, 261–262
solution-focused approaches involving, 302–304, 326, 332–333
structure and organization of, 320–323, 329–330
Family Cluster program, 337
Family Educational Rights and Privacy Act (FERPA), 38, 44, 51–52
Family therapy:
assessment in, 344
attachment-based family therapy as, 342
belief systems considered in, 324–326, 331–334, 346
case study of, 343–346
circularity considered in, 325–326
classroom/educational applications of, 337–339, 343–346
cognitive-behavioral and behavioral approaches to, 130–131, 139–140, 388
cultural considerations in, 322–323, 326
developmental issues in, 321–322, 335–336
directive family play therapy as, 334–335
disability-related interventions as, 380, 382–383, 388–389
education and training in, 319–320
efficacy of, 339–342
family-centered problem-solving intervention as, 382–383
functional family therapy as, 340–341
gender issues in, 322–323
group procedures for, 336–337, 388–389
historical perspective on, 318–320
homework assignments in, 330
interactional patterns considered in, 323–324, 325, 330–331
Internal Family Systems model of, 327–328, 335–336
journals on, 319
Medical Family Therapy as, 328, 336
multidimensional family therapy as, 341–342
multidimensional treatment foster care as, 341
multisystemic therapy as, 13–14, 341
narrative therapy as, 326, 334
overview of, 317–318, 342–343
parent counseling and training in, 336, 341
professional associations related to, 319–320
rational emotive behavior therapy as, 188–190
reality therapy as, 252–253
resources on, 319, 346–348
solution-focused therapies as, 326, 332–333
strategic family therapy as, 323–324, 330–331, 340
structural family therapy as, 320–323, 329–330, 340
systemic approaches as, 13–14, 317–346 (*see also* Systemic approaches)
theories underlying, 318, 320–328
therapeutic goals and techniques of, 329–336, 345–346
Filial therapy, 93, 97–98, 102–103, 105, 108
Freud, Anna, 2, 92
Freud, Sigmund, 2, 92
Functional behavioral assessments, 360–361
Functional family therapy, 340–341

Gays/lesbians, 74
Gender issues, 72, 262, 322–323
General systems theory, 318
Glasser, William, 217
William Glasser Institute, 220
GLBT individuals, 74
Goal setting:
child/adolescent perspective on, 8–9
in child-centered play therapy, 95–97, 103
in cognitive-behavioral and behavioral approaches, 54, 121
in culturally responsive interpersonal therapy, 70–71
developmental framework for, 6
in disability-related interventions, 361, 371
in family therapy, 330
in rational emotive behavior therapy, 179, 181–182, 184, 201–202
in reality therapy approaches, 230–231, 237–238
in school-based interventions, 54
in solution-focused approaches, 286, 293, 307–308
Gross v. Allen (1994), 46
Group therapy:
child-centered play therapy as, 92, 102, 103–104
cognitive-behavioral and behavioral approaches in, 129, 135, 141–142
confidentiality issues in, 38–39, 54
disability-related interventions including, 374, 376, 388–389
rational emotive behavior therapy as, 185–186, 190, 198
reality therapy as, 240–242, 258, 260–262
research on, 18
solution-focused approaches in, 298–300
systemic approaches to, 336–337, 388–389 (*see also* Family therapy)

Handbook of Psychotherapy and Behavior Change, 15
Harrington, G. L., 217
Health Insurance Portability and Accountability Act (HIPAA), 28, 52–53

Homicide attempts and ideation, 41, 45–46, 47
Homosexuality, 74
Humanistic psychotherapy, 376

Individuals with Disabilities Education Improvement Act (IDEA), 3, 32, 44, 53, 54, 365, 372, 384
Inference chaining, 179–180
Informed consent, 28, 32–33, 34, 35, 41–42, 49–51
Institute for Advanced Study in Rational Psychotherapy, 158, 186
Institute for Reality Therapy, 218, 220
Insurance coverage, 286
Intellectual/developmental disabilities:
  assessment or identification of, 365
  children/adolescents with disabilities with, 298, 306, 359, 365–371, 390
  cognitive-behavioral and behavioral approaches to, 367–370
  comorbid conditions with, 359, 366–367, 368–370
  medication for, 370
  parent training related to, 368
  prevalence of, 365
  progress monitoring of, 370–371
  resources on, 390
  solution-focused approaches for, 298, 306, 370
  therapeutic approaches to, 367–370
Internal Family Systems model, 327–328, 335–336
International Family Therapy Association, 319, 320
International Journal of Choice Theory and Reality Therapy, 220
Internet- or computer-based issues:
  computerized CBT treatments as, 136–137
  confidentiality risks as, 39, 52–53
  legal issues related to, 52–53
  rational emotive behavior therapy game and technology inclusion as, 184, 198, 199
Interpersonal psychotherapy:
  child/adolescent application of, 66–67
  culturally responsive, 61–86
Interpreters, 40–41
Interventions. *See* Child/adolescent counseling and psychotherapy

James, William, 280
Joining, 329, 337–338
Journal of Reality Therapy, 220, 264
Juvenile delinquency. *See* Delinquent behavior

Kelson v. City of Springfield (1985), 47
Klein, Melanie, 2

Latino/a Americans, 68–69, 76, 81–82, 106
Learning disabilities:
  assessment or identification of, 83, 372
  children/adolescents with disabilities with, 53, 83, 196, 200, 371–377, 385, 390
  cognitive-behavioral and behavioral approaches to, 374, 375–376
  comorbid conditions with, 372, 373–374, 376, 385
  group counseling for, 374, 376
  humanistic psychotherapy for, 376
  mindfulness training for, 376
  parent training related to, 375
  prevalence of, 371–372
  progress monitoring of, 376
  REBT for response to, 196, 200
  resources on, 390
  school-based interventions for, 53, 83, 200, 371–377
  social skills training for, 375, 376
  solution-focused approaches for, 374–375
  therapeutic approaches to, 53, 196, 200, 373–376
Legal issues:
  child abuse reporting as, 48–49
  confidentiality and privilege as, 38, 43–49, 54
  duty to inform as, 46–47
  duty to warn as, 45–46, 47–49
  ethical issue distinction from, 26–27, 28, 42, 48, 50, 55
  informed consent as, 49–51
  medication trials as, 50–51
  overview of importance of, 26, 42–43, 55
  parental rights and responsibilities as, 36, 44, 49–52
  records access and privacy as, 38, 44–45, 51–53
Lesbians/gays, 74

Medical Family Therapy (MedFT), 328, 336
Medical health issues, 328, 336, 337, 340, 341, 343–345, 384–389. *See also* Disabilities, children and adolescents with
Medication, 42, 50–51, 126, 370
Mental health issues:
  anxiety as (*see* Anxiety and anxiety disorders)
  assessment of (*see* Assessment and diagnosis)
  attention deficit hyperactivity disorder as, 5, 51, 97, 141, 372, 374, 376, 379
  autism spectrum disorders as, 5, 358–365, 389–390
  behavioral and conduct disorders as (*see* Behavioral and conduct disorders)
  bipolar disorder as, 360
  chronic nature of, 3–5
  depression as (*see* Depression and depressive disorders)
  eating disorders as, 46, 141, 142, 196, 321, 340
  obsessive-compulsive disorder as, 124, 129–131, 196, 360, 364
  posttraumatic stress disorder as, 124, 134–135, 140, 141, 143–147, 380
  schizophrenia as, 282, 318
  social phobia as, 17, 131–134, 191, 197
  substance abuse as, 4, 5, 196, 282, 298, 341–342
  suicide attempts and ideation as, 5, 41–42, 46–47, 74, 135–136
  treatment of (*see* Child/adolescent counseling and psychotherapy)
Mental health professionals. *See* Therapists and counselors

Mental Research Institute (MRI), 280, 318
Milligan et al. v. City of Slidall (2000), 47
Mindfulness training, 123, 376
Minority cultural issues. *See* Cultural issues; *specific minority groups*
Minuchin, Salvador, 329
Minuchin Center for the Family, 329
Miracle questions, 291–293, 332–333
Miranda v. Board of Education of the City of New York (1994), 47
Multicultural issues. *See* Cultural issues
Multidimensional family therapy (MDFT), 341–342
Multidimensional treatment foster care, 341
Multimodal and multisystemic approaches, 12–14, 341. *See also* Systemic approaches
Multisystemic therapy (MST), 13–14, 341

Narrative therapy, 326, 334
National Association of School Psychologists (NASP), 27, 33, 34, 40, 50, 53
National Council on Family Relations, 320
Native Americans, 79–80
Nonverbal communication, 75, 100
Normalization, 130
Nurturing Parent Program, 336

Obsessive-compulsive disorder (OCD), 124, 129–131, 196, 360, 364
Online issues. *See* Internet- or computer-based issues

Page v. Rotterdam-Mohonasen Central School District (1982), 52
Parent-Child Interaction Therapy (PCIT), 368
Parent counseling and skills training. *See also* Family therapy
  child-centered play therapy including, 93, 103, 104–105, 108
  cognitive-behavioral and behavioral approaches to, 141, 142, 364–365, 375
  disability-related support including, 358, 364–365, 368, 375, 382–383
  family therapy including, 336, 341
  Nurturing Parent Program as, 336
  Parent-Child Interaction Therapy as, 368
  Parent Involvement Program as, 250–252, 257–258
  rational emotive behavior therapy including, 187–191, 198, 200, 202
  Rational Positive Parenting as, 190, 198
  reality therapy approaches to, 250–252, 257–258, 261–262
  solution-focused approaches to, 302
  stress management as, 383
Parent Involvement Program (PIP), 250–252, 257–258
Parents. *See* Families and parents
Parents Against Abuse in Schools v. Williamsport Area School District (1991), 52
Personality:
  cognition influenced by, 115–116
  developmental issues relate to, 6, 10
  psychoanalysis on, 91–92
  subpersonalities, 327–328, 335–336
Pesce v. J. Sterling Morton High School District 201 (1987), 48
Pharmacological treatments, 42, 50–51, 126, 370
Phyllis P. v. Claremont Unified School District (1986), 38, 48
Physical disabilities. *See also* Medical health issues
  children/adolescents with disabilities with, 384–389, 391
  cognitive-behavioral and behavioral approaches to, 386–388
  comorbid conditions with, 385, 387
  coping skills therapies related to, 387
  family and parent issues with, 385–386, 388–389
  family therapy related to, 388–389
  problem solving training related to, 387
  relaxation training related to, 386–387
  resources on, 391
  therapeutic approaches to, 386–389
Piaget's theory of cognitive development, 6–7, 125
Play therapy:
  child-centered, 2–3, 91–109
  directive family play therapy as, 334–335
  filial therapy including, 93, 97–98, 102–103, 105, 108
  history and status of, 2–3, 91–93
Posttraumatic stress disorder (PTSD):
  cognitive-behavioral and behavioral approaches to, 124, 134–135, 140, 141, 143–147
  comorbid conditions with, 134
  traumatic brain injury response including, 380
Privacy, 38, 44–45, 51–53
Privilege. *See* Confidentiality and privilege
Problem solving:
  cognitive-behavioral and behavioral approaches including, 120, 122, 126, 127, 132, 136, 138, 145, 387
  culturally responsive interpersonal therapy including, 71–76
  family-centered problem-solving intervention as, 382–383
  rational emotive behavior therapy practical solutions including, 175–177, 177–178
  reality therapy approaches including, 244–245
  SOLVE model of, 387
Psychoanalysis, 2, 91–92, 116–117, 318
Psychoeducation:
  cognitive-behavioral and behavioral approaches including, 123, 127, 129–130, 131, 133, 134, 136, 140, 145, 364–365
  rational emotive behavior therapy as, 156, 186, 199
Psychotherapy. *See* Child/adolescent counseling and psychotherapy
Punishment avoidance, 233–235, 248, 271

Racial and ethnic cultural issues. *See* Cultural issues; *specific minority groups*
Rational emotive behavior therapy (REBT):
13 steps of, 178–181
adaptive and maladaptive emotions in, 161–162
for adolescents, specifically, 184–185
assessment in, 188–189
awfulizing in, 165, 166, 167, 169, 171
case study of, 200–205
CBT foundations of, 115, 155
for children, specifically, 183–184
classical *vs.* general, 155
classroom/educational applications of, 186–187, 197, 199
demandingness in, 163, 164, 166–169, 171, 173
developmental issues considered in, 181, 184–185
disputing irrational beliefs in, 180–181, 184–185
distinctive features of, 156–157
education and training in, 158
efficacy of, 192–199
elegant *vs.* inelegant solutions in, 177–178
familial and parental involvement in, 187–191, 198, 200, 202, 204–205
frustration intolerance in, 165, 166, 167, 169–170, 171
global evaluation of human worth in, 165, 167, 170–171, 173
goal setting in, 179, 181–182, 184, 201–202
group setting for, 185–186, 190, 198
history and status of, 157–158
homework assignments in, 181, 191, 205
hypothesis presentation in, 180
individual psychotherapy as, 181–185, 189, 190–191
inference chaining in, 179–180
insights developed in, 178
irrational beliefs and emotional disturbance in, 163–166, 167, 171–173
overview of, 155–157, 199–200
philosophical assumptions of, 158–159
practical *vs.* emotional solutions in, 175–177
primary and secondary disturbances in, 173
principles of, 160–161
Rational Positive Parenting based on, 190, 198
religious versions of, 156–157
research support for, 171, 173
resources on, 158, 205–207
RETMAN rational stories in, 184, 198, 199
self-acceptance *vs.* self-esteem in, 170–171, 173
stress management program including, 187
theoretical assumptions of, 159–161
therapeutic relationship development in, 174–175, 182, 188
therapeutic strategies and techniques in, 174–199
unconditional acceptance in, 174–175
values of, 159–160
view of psychopathology in, 161–173
Reality therapy approaches:
10-step discipline plan as, 245–250
to acting out/behavior issues, 217–218, 225, 229, 242, 244–250, 253–254, 258–263
basic theory and assumptions of, 221–224
bibliotherapy in, 239–240
case studies of, 219, 245–250, 266–271
CBT foundations of, 115
choice theory underlying, 220, 223–224, 236–240, 263–264
classroom/educational applications of, 217–218, 243–250, 253, 254–257, 258–264, 266–271
commitment to plan in, 231–232, 245, 268–270
confrontation in, 238
contracts in, 232, 238, 248, 268, 269
control theory underlying, 219–220, 222–223
counseling environment for, 236–237
criticism in, 233, 235
to depression and withdrawal, 224–225, 229
developmental issues considered in, 242, 262
education and training in, 218, 220, 261, 263
efficacy of, 253–265
excuse avoidance in, 232–233, 270
family interventions in, 252–253
freedom in, 222, 243, 262
fun and enjoyment in, 221, 222, 243, 262
gender issues considered in, 262
group procedures for, 240–242, 258, 260–262
history and status of, 217–220
homework assignments in, 239
humor in, 238
identity development in, 218, 221, 225
individual psychotherapy as, 227–236
information in, 239
instruction in, 239
involvement of therapist in, 227–228, 240, 241, 267–268, 271
love and belonging in, 221, 222, 226, 243, 262
overview of, 265–266
paradox in, 240
parenting skills training in, 250–252, 257–258, 261–262
persistence in, 235–236
planning responsible behavior in, 230–231, 237–238, 241, 244–245, 247–248, 268–270, 271
power/sense of importance in, 221, 243, 262
present behavior focus in, 228–229, 237, 241
punishment avoidance in, 233–235, 248, 271
questioning in, 240, 247
resources on, 272–273
restitution in, 240
role playing in, 239
Schools without Failure as, 218, 258
self-disclosure in, 240
to sickness, 225–226
summarizing in, 228, 231, 240
support in, 239
theories underlying, 219–224
therapeutic goals and techniques in, 226–227, 237–240
therapeutic relationships in, 227–228, 235–236, 236–237, 240, 241, 266–268, 271

to thinking disturbances, 225
value judgment in, 229–230, 231, 232–233, 266, 271
view of psychopathology in, 224–227
Records management, 38, 39, 44–45, 51–53
Reflection, 100, 107, 108
Reframing, 126, 134, 177, 331–332, 338–339, 346, 388
Relapse prevention, 121, 128
Relaxation training, 123, 126, 128, 132, 134, 363, 386–387
Religion and spirituality, 78–79, 82, 156–157
Research:
effect size determinations in, 18–19
efficacy studies in (*see* Efficacy of treatments; Evidence-based treatments)
historical and traditional reviews of, 14–18
meta-analyses of, 18–20
Rogers, Carl, 2–3
Role playing:
cognitive-behavioral and behavioral approaches including, 122, 123, 124, 126, 128, 133, 138, 141, 362
culturally responsive interpersonal therapy including, 76
rational emotive behavior therapy including, 191, 204–205
reality therapy approaches including, 239

Safety planning, 135
Schizophrenia, 282, 318
School-based interventions:
10-step discipline plan as, 245–250
child-centered play therapy as, 105–106
child teacher relationship training as, 105, 106
chronic mental health needs necessitating, 4
classroom meetings as, 243–245, 255–257, 264
cognitive-behavioral and behavioral approaches to, 53–54, 141
counselor competence for, 29–30
counselor private practice with clients from, 30–31
culturally responsive interpersonal therapy as, 82–85
disability-related interventions as, 53, 83, 200, 299, 357, 365, 371–377, 379, 380–381
ethical issues with, 29–42, 53–54
evidence-based, 53
goal setting in, 54
group setting for, 39, 141
historical perspectives on, 3
Individuals with Disabilities Education Improvement Act on, 3, 32, 44, 53, 54, 365, 372, 384
learning disabilities addressed in, 53, 83, 200, 371–377
legal issues with, 44–53
medication in, 51
parental role in/consent for, 32–33, 34, 35–37, 41–42, 44, 49–51
rational emotive behavior therapy as, 186–187, 197, 199
reality therapy approaches as, 217–218, 243–250, 253, 254–257, 258–264, 266–271
school phobia/refusal necessitating, 17, 133–134
Schools without Failure as, 218, 258
school violence necessitating, 41, 47
solution-focused approaches as, 282, 300–304, 306
systemic approaches to, 337–339, 343–346
traumatic brain injury and, 379, 380–381
School phobia, 17, 133–134
Self-esteem *vs.* self-acceptance, 170–171, 173
Self-instructional training, 115
Self-monitoring, 122–123, 127
Self-regulation/self-management, 123, 127, 363
Sexuality:
adolescent sexual identity, 72, 74
ethical issues related to, 42
sexual abuse, 143–147, 282
sexual orientation, 74
Social phobia, 17, 131–134, 191, 197
Social skills training, 132, 138, 141, 362, 375, 376, 383
Social Stories&, 362, 363
Society of Clinical Psychology, 20
Socioeconomic status, 75, 106
Socratic questioning, 121
Solution-focused approaches:
basic theory and assumptions of, 282–285
case studies of, 291–292, 297–298, 299–300, 307–309
change and fluctuation awareness in, 284
classroom and parent applications of, 282, 300–304, 306
collaboration enhancing change in, 282–283, 287–288
complimenting clients in, 296, 297
developmental issues considered in, 287
diagnosis avoidance in, 285–286
dialogue/language importance in, 281, 283–284
disability-related interventions as, 298, 306, 370, 374–375
effectiveness research on, 304–307
exceptions focus in, 294–295, 296–297, 299, 308–309, 333
family therapy as, 326, 332–333
feedback messages in, 297–298, 308
future solutions *vs.* past problems focus in, 281, 283
group work including, 298–300
history and status of, 280–282
miracle questions in, 291–293, 332–333
overview of, 279–280, 307
postmodern thinking/social constructionism underlying, 281, 326
pragmatic philosophy of, 284–285
previous solutions/theories exploration in, 288–289
questions asked in, 289–295, 299, 307, 332–333
resources on, 310
ripple effect in, 284
solution-focused brief therapy as, 280–281, 305–306, 333, 370, 374–375
strengths-based approach in, 284–285, 296
Taking Charge program as, 302
theories underlying, 281, 282–286, 326

Solution-focused approaches (*continued*)
therapeutic goals and interventions in, 286–298
view of psychopathology in, 285–286
WOWW program as, 301–302
Solution-Focused Brief Therapy Association (SFBTA), 281
SOLVE model, 387
Somatic complaints/management, 127, 136, 142, 225–226, 340
Stages of change model, 181–182
Strategic family therapy, 323–324, 330–331, 340
Stress management, 134, 140, 187, 383. *See also* Relaxation training
Structural family therapy, 320–323, 329–330, 340
Substance abuse, 4, 5, 196, 282, 298, 341–342
Suicide attempts and ideation, 5, 41–42, 46–47, 74, 135–136
Supersedingconfidentiality and privilege:
child abuse concerns superseding, 37–38, 48–49
duty to inform superseding, 46–47
duty to warn superseding, 45–46, 47–49
ethical issues of, 28–29, 35, 37–39, 48
group therapy issues of, 38–39, 54
Internet- or computer-based risks to, 39, 52–53
legal issues of, 38, 43–49, 54
privilege *vs*. confidentiality distinction, 43, 48
Surviving Cancer Competently Intervention Program (SCCIP), 388
Systemic approaches:
assessment in, 344
attachment-based family therapy as, 342
belief systems considered in, 324–326, 331–334, 346
case study of, 343–346
circularity considered in, 325–326
classroom/educational applications of, 337–339, 343–346
cultural considerations in, 322–323, 326
developmental issues in, 321–322, 335–336
directive family play therapy as, 334–335
education and training in, 319–320
efficacy of, 339–342
family therapy as, 13–14, 317–346 (*see also* Family therapy)
functional family therapy as, 340–341
gender issues in, 322–323
general systems theory underlying, 318
group procedures for, 336–337, 388–389
historical perspective on, 318–320
homework assignments in, 330
interactional patterns considered in, 323–324, 325, 330–331
Internal Family Systems model as, 327–328, 335–336
joining in, 329, 337–338
journals on, 319
Medical Family Therapy as, 328, 336
multidimensional family therapy as, 341–342
multidimensional treatment foster care as, 341
multisystemic therapy as, 13–14, 341
narrative therapy as, 326, 334
overview of, 317–318, 342–343
parent counseling and training in, 336, 341
professional associations related to, 319–320
reframing in, 331–332, 338–339, 346
resources on, 319, 346–348
solution-focused therapies as, 326, 332–333
strategic family therapy as, 323–324, 330–331, 340
structural family therapy as, 320–323, 329–330, 340
theories underlying, 318, 320–328
therapeutic goals and techniques of, 329–336, 345–346

Taking Charge program, 302
Tarasoff v. Regents of the University of California (1976), 45–46, 47, 48
Therapeutic relationships:
adolescent challenges to, 11–12
child-centered play therapy goals for, 95–97, 99, 101, 109
culturally responsive, 64–66
rational emotive behavior therapy focus on, 174–175, 182, 188
reality therapy approach to, 227–228, 235–236, 236–237, 240, 241, 266–268, 271
solution-focused approaches to, 282–283, 287–288
systemic approach focus on, 329, 337–338
unconditional acceptance/positive regard in, 96, 174–175
Therapists and counselors:
competence of, 29–30, 39, 62–66
cultural issues impacting (*see* Cultural issues)
education and training of, 29–30, 39, 158, 218, 220, 261, 263, 319–320
ethical issues for (*see* Ethical issues)
legal issues for (*see* Legal issues)
multiple relationships of, 31
professional relationships and communication among, 29, 357–358, 370
self-awareness of, 65
self-disclosure by, 240
therapeutic relationship with (*see* Therapeutic relationships)
treatment by (*see* Child/adolescent counseling and psychotherapy)
Transgender individuals, 74
Traumatic brain injury:
children/adolescents with disabilities with, 377–383, 390–391
cognitive-behavioral and behavioral approaches to, 380, 382
comorbid conditions with, 379–380, 382
family and parent issues related to, 381
family therapy/parent intervention for, 380, 382–383
hospitalization for, 377, 380
pathophysiology and impact of, 377–379
prevalence of, 377
resources on, 390–391
school reentry after, 380–381

social interventions for, 383
therapeutic approaches to, 380, 381–383
Treatments. *See* Child/adolescent counseling and psychotherapy

Unconditional acceptance/positive regard, 96, 174–175
Understanding Us program, 337

Valerie v. Derry CO-OP School District (1991), 51
Violence:
domestic (*see* Child abuse; Domestic violence)
homicide attempts and ideation as, 41, 45–46, 47
school-based, 41, 47
suicide attempts and ideation as, 5, 41–42, 46–47, 74, 135–136

White Americans, 69
William Glasser Institute, 220
Wittgenstein, Ludwig, 280
WOWW (Working on What Works) program, 301–302

You Can Do It program, 186–187
Youth. *See* Children and adolescents

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